2027 Child and Adult Core Sets Annual Review:
Meeting to Review Measures for the 2027 Core Sets, Day 2 Transcript
February 5, 2025, 11:00 AM – 4:30 PM ET

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I'm pleased to welcome you to the 2027 Child and Adult Core Sets Annual Review Meeting to Review Measures for the 2027 Core Sets, Day 2. Before we get started today, we wanted to cover a few technical instructions.

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

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

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

Patricia Rowan:

Great, thank you, Talia. Welcome back, everybody, for Day 2 of the Meeting to Review Measures for the 2027 Child and Adult Core Sets. Hope everyone had a nice rest of their day yesterday.

We had a very productive day yesterday and a robust discussion on four measures. We started the day by discussing two measures that were suggested for removal, the Contraceptive Care: Postpartum Women and Contraceptive Care: All Women measures. The Workgroup voted not to recommend removal of either of those measures yesterday during the meeting.

In the afternoon, we discussed the first two measures that were suggested for addition. The first one was the Antibiotic Utilization for Respiratory Conditions measure. The Workgroup did not recommend addition of that measure to the 2027 Core Sets. The second measure that was discussed for addition yesterday was the Evaluation of Hepatitis B and C measure, and the Workgroup did recommend adding that measure to the 2027 Core Set.

We're looking forward today to discussing the final four measures that were suggested for addition to the 2027 Core Sets and getting input from the Workgroup on next year's public Call for Measures. Before we begin, we will open up our day with comments from Kim Elliott and Rachel La Croix, our two Co-Chairs, for some brief welcome remarks.

Kim, would you like to start?

Kim Elliott:

Sure, I'm happy to start. Yesterday was really a great day from a meeting perspective. We discussed some really interesting measures, and the discussion was very thoughtful. Everybody was well prepared for the discussions, really understood the measures, the resources available from a state perspective. I think the format that Mathematica has implemented to really have the state agencies discuss these measures first was an effective way to really understand how the states use the measures, any impacts on resources, things that were working well or perhaps were a bit of a struggle or a challenge for state agencies were also very informative.

I'm looking forward to today's discussion as much as yesterday's, and of course I'm also looking forward to our discussion on gaps. Rachel?

Rachel La Croix:

Thanks, Kim. Good morning, everyone. I just want to echo Mathematica's and Kim's welcome to everyone. I am very much looking forward to our discussion today as well. I know we have four other proposed addition measures to discuss today, so I'm really looking forward to hearing everyone's feedback on those measures and hopefully hearing from some folks who may already be using some of these measures or have some information to share about potential uses for these measures and how they would fit well with the rest of the Core Sets and address some areas we might not have covered already.

Similarly, I'm looking forward to our discussion of gap areas later. I know that's always a really interesting part of our meeting and like hearing everyone's feedback and thoughts on those areas. It's always great to see gap areas where we have been able to go ahead and adopt some measures and so have some areas that are no longer gaps to the extent that they were before. So that's always an interesting part of the conversation as well.

So welcome and I look forward to another good, robust conversation today.

Patricia Rowan:

Thanks so much, Kim and Rachel. Next slide.

So, we will conduct a roll call of the Workgroup members this morning just to make sure everybody's present and accounted for. Next slide.

We ask that Workgroup members, similar to yesterday, use the "raise hand" feature when your name is called in WebEx. We will unmute you, and you can say hello. Please ensure that you're not also muted on your headset or phone. Once you're done, you can mute yourself in the platform and lower your hand. We'll repeat that later in the day. If you'd like to speak again, you can use the "raise hand" function again; and we'll unmute you at that time. Next slide.

All right, so we've already heard from Kim and Rachel. So, we'll start with Benjamin Anderson. Is Ben here? Go ahead, Ben.

Benjamin Anderson:

Here.

Patricia Rowan:

Thanks for being here.

Next, we have Rich Antonelli. Go ahead, Rich.

Richard Antonelli:

Hello?

Patricia Rowan:

Hi, Rich. We can hear you. Just wanted to make sure everything was good with the audio. Thanks for being here.

Do we have Palav Babaria? I think Palav was not able to join us, unfortunately.

All right, Stacey Bartell – can we unmute Stacey? Go ahead, Stacey.

Stacey Bartell:

I'm here.

Patricia Rowan:

Great.

Laura Boutwell? Go ahead, Laura.

Laura Boutwell:

Good morning.

Patricia Rowan:

Good morning, thank you for being here.

Next, we have Matt Brannon. Let's unmute Matt. Go ahead, Matt.

Matt Brannon:

Good morning, everyone.

Patricia Rowan:

Good morning, thank you for being here.

Emily Brown. Go ahead, Emily. Emily, can you hear us okay?

Emily Brown:

Yes, good morning.

Patricia Rowan:

Great, good morning.

Next, we have Joanne Bush. Let's unmute Joanne. Go ahead, Joanne. Can you hear us okay, Joanne?

Joanne Bush:

Yes, I can. Can you hear me?

Patricia Rowan:

Yes, we can.

We have Stacey Carpenter. Let's unmute Stacey. Go ahead, Stacey.

Stacey Carpenter:

Hey, everyone, looking forward to the day.

Patricia Rowan:

Good morning, thank you for being here. Let's go to the next slide.

Roshanda Clemons – let's unmute Roshanda. Roshanda, go ahead.

Roshanda Clemons:

Good morning. Can you hear me?

Patricia Rowan:

Good morning. We can hear you just fine, thank you.

Roshanda Clemons:

Okay, thank you.

Patricia Rowan:

Lindsay Cogan – unmute Lindsay. Go ahead, Lindsay. Lindsay, are you there? Can you hear us?

Lindsay Cogan:

I can hear you. Can you hear me?

Patricia Rowan:

Great, we can hear you now, yeah.

Lindsay Cogan:

Great.

Patricia Rowan:

Thank you.

Erica David-Park – can you unmute Erica? Go ahead, Erica.

Erica David-Park:

Good morning. Can you hear me?

Patricia Rowan:

Yes, we can. Thanks for being here.

Erica David-Park:

Thank you.

Anne Edwards – let's unmute Anne. Go ahead, Anne. Can you hear us, Anne?

Anne Edwards:

I can. Can you hear me?

Patricia Rowan:

Yes, we can. Thanks for being here.

Clara – do we have Clara? Let's unmute Clara. Clara? Go ahead, Clara.

Clara Filice:

Hello, good morning.

Patricia Rowan:

Great.

Angela – can we unmute Angela? Go ahead, Angela.

Angela Filzen:

Can you hear me?

Patricia Rowan:

Yes, we can. Thank you for being here.

Angela Filzen:

Thank you.

Patricia Rowan:

Sara Hackbart – are you there, Sara?

Sara Hackbart:

Yeah, good morning.

Patricia Rowan:

Great, good morning. We're hearing from the audience that there is a bit of a sound delay. So, we'll just ask folks to kind of speak up into their microphone if you can. I appreciate it.

Next, we have Richard Holaday. Is Richard here? Go ahead, Richard. Go ahead.

We might have lost Richard's audio, but we will go to Jeff. Can we unmute Jeff? Go ahead, Jeff.

Jeff Huebner:

Good morning. Can you hear me?

Patricia Rowan:

Yep, we can hear you now. Great, thank you.

Okay, and let's go to David Kelley. Go ahead, David.

David Kelley:

Can you hear me?

Patricia Rowan:

Yes, we can. Thanks, David.

Let's see if we can hear Richard Holaday yet. Okay, we'll come back to Richard. Let's go to the next slide.

David Kroll – let's unmute David. Go ahead, David. David, can you raise your hand one more time. We didn't quite hear you.

David Kroll:

Oh, hi, can you hear me now?

Patricia Rowan:

Yes, we can hear you now, thanks.

David Kroll:

Hi, everybody.

Patricia Rowan:

Jakenna Lebsock we heard will be a little bit late this morning.

Do we have Hannah Lee-Brown? Oh, Hannah will also be late. Thanks.

Okay, Katherine Leyba – let's unmute Katherine. Go ahead, Katherine. Katherine, can you hear us? We might have lost your audio. Okay, we'll come back to Katherine.

Chimene – do we have Chimene? Can we unmute Chimene? Go ahead.

Chimene Liburd:

I'm here.

Patricia Rowan:

Great, thank you.

Angela Parker – can we unmute Angela? Go ahead, Angela. We've lost Angela's audio as well.

Let's try Lisa Patton. Can we unmute Lisa? Go ahead, Lisa.

Let's try Angela again. Can we unmute Angela? Angela, go ahead.

Angela Parker:

Hello?

Patricia Rowan:

Yep, we can hear you now. Thank you for sticking with us.

Angela Parker:

Okay, thank you.

Patricia Rowan:

Let's try Lisa again. Are you there, Lisa?

Lisa Patton:

Yes, I'm here. Hi there.

Patricia Rowan:

Wonderful, thanks for being here.

Laura Pennington – are you there, Laura? Go ahead, Laura.

Laura Pennington:

Good morning, I'm here. Can you hear me?

Patricia Rowan:

We can, yes, thank you.

Do we have Grant Rich? Let's unmute Grant. Go ahead, Grant.

Grant Rich:

I'm here.

Patricia Rowan:

Great, thank you.

Lisa Satterfield – do we have Lisa? Is Lisa Satterfield in the audience? Make sure to use that "raise hand" feature. We can come back to Lisa. Let's go to the next slide.

Bonnie Silva – can we unmute Bonnie? Go ahead, Bonnie.

Bonnie Silva:

Good morning, I'm here.

Patricia Rowan:

Okay, good morning, thank you. Kai – can we unmute Kai? Go ahead, Kai. Are you there, Kai?

Kai Tao:

Can you hear me?

Patricia Rowan:

Yes, we can hear you now, thank you.

Kai Tao:

Great, thank you.

Patricia Rowan:

Sarah Tomlinson – Can we unmute Sarah? Go ahead, Sarah. Okay, we might have also lost Sarah. We're having lots of audio issues with our WebEx, folks. Thank you for sticking with us. Sarah, can we try you again? Can you hear us, Sarah? Are you there, Sarah? Sarah, we are not hearing you; but we see that you are here.

Let's try Bonnie Zima. Can you unmute Bonnie? Go ahead, Bonnie.

Bonnie Zima:

Good morning, good morning.

Patricia Rowan:

Good morning, thank you for being here.

All right, anybody that I had to skip over for audio issues want to try again? I know we lost -- Richard Holaday was working on audio issues. Lisa Satterfield, Sarah Tomlinson. Let's try Richard again.

Go ahead, Richard.

Richard Holaday:

Can you hear me now?

Patricia Rowan:

We can, yes! Thank you, Richard.

Richard Holaday:

Great, thank you.

Patricia Rowan:

Appreciate it.

Who else? Hannah – I think Hannah Lee-Brown might have joined us. Is Hannah there?

All right, well, in the interest of time, I am going to move on from the roll call. But we will continue troubleshooting audio. If folks are having issues, please use the Q&A feature. That comes right to our team.

Let's try Sarah Tomlinson again. I see Sarah's hand up. Sarah, go ahead. Are you hearing us, Sarah? Nope, no Sarah. Derek, our producer, will work with you, Sarah. Sorry about the frustration. All right, let's move on to the next slide.

Okay, as I mentioned yesterday, we are also joined by federal liaisons who are non-voting members of the Workgroup. Federal liaisons are in listen-only mode for today's discussion, but they represent the agencies listed here on this slide.

I would also like to acknowledge the members of the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services who are listening to today's meeting as well.

We also have measure stewards on for each of the measures that are being discussed, and we thank them for being available to answer questions about their measures as well. Next slide.

All right, we'll kick it off with the substance of the day. I'm going to turn it to my colleague, Deb, who will present the next measure suggested for addition.

Deb Haimowitz:

Thanks, Tricia. The next measure suggested for addition to the 2027 Core Sets is Depression Remission or Response for Adolescents and Adults. Next slide, please.

Before we get started on this measure, we wanted to provide some context on the existing related measures on the Core Sets. Our aim is to provide context to help Workgroup members consider whether the suggested measure fills a gap in the Core Sets or adds value to the existing measure set.

The 2026 Child Core Set includes three measures related to depression screening and treatment for adolescents. The Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure assesses the percentage of beneficiaries screened for depression on the date of the encounter, or 14 days prior to the date of the encounter, using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the qualifying encounter.

The Postpartum Depression Screening and Follow-Up: Under Age 21 measure assesses the percentage of deliveries in which beneficiaries were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care.

The Prenatal Depression Screening and Follow-Up: Under Age 21 measure assesses the percentage of deliveries in which beneficiaries were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Next slide, please.

The 2026 Adult Core Set includes the same three measures related to depression screening and treatment but for adult age ranges. Note that the Prenatal and Postpartum Depression Screening measures are provisional Core Set measures and are voluntary for 2026 reporting on both the Child and Adult Core Sets.

Note also that the Adult Core Set previously contained a fourth measure related to depression treatment for adults, Antidepressant Medication Management. As we mentioned yesterday, this measure has been retired by the measure steward and was removed from the 2026 Adult Core Set. Next slide, please.

Let's now turn to the measure suggested for addition to the Core Sets, Depression Remission or Response for Adolescents and Adults. This measure is defined as the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score who had evidence of response or remission within 120 to 240 days, or four to eight months, of the elevated score. The PHQ-9, or Patient Health Questionnaire 9, is a nine-item depression module that assesses mental health disorders.

The following rates are reported for this measure;

- Follow-Up PHQ-9, defined as the percentage of members who have a follow-up PHQ-9 score documented within 120 to 240 days after the initial elevated PHQ-9 score;
- Depression Remission, defined as the percentage of members who achieved remission within 120 to 240 days after the initial elevated PHQ-9 score; and
- Depression Response, defined as the percentage of members who showed response within 120 to 240 days after the initial elevated PHQ-9 score.

The National Committee for Quality Assurance, or NCQA, is the measure steward; and the measure is specified at the health plan level. As we previously mentioned, there are behavioral health measures already on the Core Sets related to this measure. However, the individual who suggested this measure highlighted that those measures indicate whether a depression screening has occurred and if there was follow-up. By contrast, the individual who suggested the measure felt that this measure is unique in that it is an outcome measure that would indicate the results of depression screenings, as well as the efficacy of the follow-up on positive screening results. Next slide, please.

The data collection method is HEDIS Electronic Clinical Data Systems or ECDS. ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges or clinical registries. The denominator for this measure includes members ages 12 and older as of the start of the intake period, which is defined as May 1st of the year prior to the measurement period through April 30th of the measurement period.

Members must meet the criteria listed on the slide, including: meet the criteria for participation, which will be shown on the next slide, and meet the depression and PHQ-9 total score requirements as described by the index episode start date or IESD. The IESD is the earliest date during the intake period when a member has a PHQ-9 total score greater than 9 that is documented within a 31-day period, including 15 days before and 15 days after an interactive outpatient encounter with a diagnosis of major depression or dysthymia. Next slide, please.

The denominator definition for this measure continues on this slide with the participation requirements. Participation for this measure includes the allocation criteria and continuous enrollment criteria listed below. This measure includes numerators for the following three rates:

- Depression Follow-Up, defined as a PHQ-9 total score in the member's record during the depression follow-up period or 120 to 240 days after the IESD;
- Depression Remission, defined as members who achieved a remission of depression symptoms as demonstrated by the most recent PHQ-9 total score of less than 5 during the depression follow-up period; and
- Depression Response, defined as members who indicate a response to treatment for depression as demonstrated by the most recent PHQ-9 total score of at least 50% lower than the PHQ-9 score associated with the IESD documented during the depression follow-up period.

Next slide, please.

The measure is currently stratified by age group only. The HEDIS Measurement Year 2025 specifications include the following stratifications by age group for the Medicaid product line: ages 12 to 17, ages 18 to 44, ages 45 to 64, and ages 65 and older.

NCQA, the measure steward, noted that the measure may be considered for stratification by race and ethnicity, along with additional stratification categories, when the number of health plan submissions and average denominator sizes are significantly sufficient to support these changes.

The measure was field tested in Medicaid in 2014 using a testing database, including one Medicaid health plan with an integrated delivery system as well as aggregate data from five Medicaid health plans.

Additionally, California Medicaid is currently using this measure as part of the state's Medi-Cal Accountability Set which requires all managed care plans to report on this measure. As of 2022, Massachusetts, Pennsylvania, Washington, and Wisconsin also collect data on this measure with Massachusetts using the measure in its value-based purchasing program.

Finally, the use of Logical Observation Identifiers Names and Codes, or LOINC codes, are required to determine the results of the PHQ-9 screening, which are used for the denominator and numerator calculations for this measure.

The individual who suggested this measure stated that mental health is a priority for the Medicaid population and that depression and suicide rates for adolescents have continued to rise since the COVID-19 pandemic. The individual cited national survey data on adolescent depression and mental health, noting that the effectiveness and outcomes of mental health services may be unmeasured and unreported.

For example, the 2023 National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration notes that among adolescents aged 12 to 17 with Medicaid or CHIP coverage about 17 percent had a major depressive episode in the last year, and about 57 percent of those with a major depressive episode reported that they received mental health treatment.

According to the individual who suggested the measure, a measure that addresses outcomes from depression screenings will help determine if treatment that results from screening is lowering depression rates and potentially suicide rates of young people served by Medicaid. The results will also provide an opportunity to adjust interventions to improve, or continue to improve, outcomes from screening for depression. Next slide, please.

With that, I will pass it back to Alli to facilitate the Workgroup discussion.

Alli Steiner:

Thanks, Deb. So, we'll now invite discussion about the Depression Remission or Response for Adolescents and Adults measure from Workgroup members. First, let's hear from any Workgroup members who are using this 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 comment.

Clara Filice:

Hi, this is Clara Filice from Massachusetts. I just thought I'd share a little bit about our experience with this measure; specifically, that we previously did use the measure as described in our DSRIP Quality Incentive program from 2018 to 2022 but opted not to continue use beyond 2022. I just wanted to share specifically with regard to feasibility. Our measure applied to our ACO population level; and as the intake period for the measure required initial PHQ-9 results, we did find that denominators were low for healthcare systems with limited use of that specific depression screening instrument. In our experience over that period for each year of calculation, about 30 percent or 40 percent of our ACOs did not have denominators robust enough to support calculation of the measure, interestingly. Then just to clarify, we did apply it only at the ACO level, specifically for – we had 17 ACOs at the time that ranged in size from a couple hundred thousand to significantly larger. Actually, our smallest ones were more like – the very smallest ones in the western part of the state were more like 50,000 to 70,000 members in total; and we did use a hybrid data collection method. Thanks.

Alli Steiner:

Thanks, Clara, very helpful.

I just wanted to make an announcement that we are going to attempt to move the Workgroup members up to Panelists so that they can unmute themselves more easily. We got some feedback that it sometimes can be challenging to be able to unmute. So, I just wanted to let folks know. I will still call on you, and then you should be able to unmute yourself.

So, let's go to Laura Pennington next, please.

Laura Pennington:

Good morning, this is Laura from Washington State. So, this is a measure that we've been prioritizing in our state for a few years, mostly because we're looking at moving towards more outcomes-based measures. Our Chief Medical Officer feels like this is a better indicator of patient outcomes due to certain interventions.

So, we tracked this measure in our MCO context for a few years for reporting only. But we recently added it for pay-for-performance beginning in measurement year 2025, but it will be zero-weighted in the first year to establish a baseline. We're only going to start with a follow-up PHQ-9 sub measure. We've had lots of conversations with health plans in our state, and we understand the difficulties with reporting the measure. However, we've continued to push it forward knowing that we're going to get low numbers; and we have been seeing low numbers from both our commercial and our MCOs for the last few years. But we're continuing to work on best ways to implement this measure, including getting access to LOINC codes.

I will say while NCQA did provide benchmarks in 2024, we noticed they were very low due to a lack of reporting. This is something we hear from our health plans all the time. It's like, "But there's no benchmarks, there's no benchmarks." Well, there were benchmarks; but they were low. We do think that the more that we encourage this measure, obviously the more robust the benchmarks will be.

Lastly, we get this data through our MCOs and through our EQRO. So we acknowledge the difficulty in reporting for the fee-for-service population. But definitely we continue to look for opportunities to get that data source so we can report for all of our populations. So, if we were able to do a phased-in approach – and I think we talked about this last year – we would be thrilled if we could do that. But either way, we do support the addition of this measure.

Alli Steiner:

Thank you, Laura, very helpful.

Let's go to David Kelley next, please.

David Kelley:

Hi, good morning. In Pennsylvania, we require our MCOs to report certain electronic measures to us. This is one of them. We do not report this publicly. What we have seen is that we have seven MCOs; only four of those seven were able to meaningfully report. In calendar year 2023, we probably had over three million participants in our plans and our additive denominator across those four plans that reported was less than 1,500 individuals, so low denominators. The method of extraction was almost exclusively through EHR extraction. We do remain committed to electronic measurement. This is an outcome measure, but we just note those challenges insofar in feasibility. Thanks.

Alli Steiner:

Thanks, David, that's very helpful.

Let's see, are there any other states that are using this measure that wanted to share their state's experience before we continue on?

Let's hear from Lindsay, please. Can we move Lindsay up?

Lindsay Cogan:

Hi, yes, this is Lindsay Cogan from New York State. This measure we've struggled with the past couple years. It is one that is in in our MCO reporting, but we've had challenges and have not yet been able to publicly report due to the feasibility challenges that others have talked about. We also do get a little bit of some pushback and challenges from clinicians on some of the cutoffs in this particular measure. So, we've fielded some questions. Understandably, outcomes are definitely where we want to go in regard to our measures; but at this point, with three other measures around depression, I think we would support an addition of a measure only with the removal of others, right? So, until we're at that point where we have those process measures well established, taking that next step in moving into outcomes is obviously where we want to go. But there is a lack of real space on some of these Core Sets. So, to have four measures around depression when you have other gap areas, that's something we weigh when we think about whether we would want to add another measure on the same topic area.

Alli Steiner:

Thanks so much, Lindsay.

Let's go to Jeff next, please.

Jeff Huebner:

Good morning, everyone. I notice – and I apologize that I wasn't able to respond to the staff in regard to the question that came about Wisconsin. I know it was listed in the discussion. I've asked around within our agency and haven't been able to find information about our use of this. So perhaps there was something that was done at a pilot level in the past; but to my knowledge and as far as I know, we're not using this in any of our managed care contracts or value-based outcomes or pay for performance or anything like that.

I agree with the previous comments, and New York summarized them well. I mean, from my perspective, it is great to start moving towards outcome measures; and it's been interesting to hear about the feasibility challenges. When I did my prep in just reviewing the measure, it does seem that the denominators are quite low; and feasibility challenges still exist.

Alli Steiner:

Thanks so much, Jeff. We appreciate you sharing your state's perspective.

So, let's move – let's open it up to all Workgroup members at this point. Let's move Bonnie up, please.

Bonnie, you can unmute yourself.

Bonnie Zima:

Can you hear me?

Alli Steiner:

Yes, we can.

Bonnie Zima:

Okay, great. I really do appreciate the states' comments about feasibility because that was a big red flag for me, but a few unique comments. One is this is a relatively large time window, the four to eight in selecting the first screening. So, in thinking about this, there's going to be variable time points for the screener. I understand it's at the health plan level; but again, you're going to get a pretty wide interval there between when that next screen occurs. The other is I'm concerned about data interpretation. You're going to have attrition at four to eight. So, what happened to those patients that didn't complete that second follow-up or that first follow-up? The other is how do you interpret this? If there is improvement and the person is still in care, is that good care or overuse? Or if there's no improvement and the person is still in care, like eight months later, is that poor care or is that patient like treatment-resistant and still needs care and maybe there's a lot of adjunctive treatment going on or even considering things like TMS? Then my third comment is really to the person who proposed it. I think we have to be really careful here that this dataset is service users. So, we really can't make any assumptions about change in prevalence of major depression given how poor access to care is. Thank you.

Alli Steiner:

Thanks so much, Bonnie.

Let's hear from David Kroll next, please.

David Kroll:

Hi, all. You can hear me?

Alli Steiner:

We can, thank you.

David Kroll:

All right, I'll be brief because I think Bonnie very eloquently said many of the things that I was going to share, but one additional thought. I think there are good and bad things about this measure. One of the good things about this is that it incentivizes measurement-based care, right? Like creating some incentive of doing the heavy lifting of trying to get these PHQ-9's into the hands of patients and having them trackable in a way that can be abstractable from a quality standpoint is actually a good thing. It's actually something that as a field in psychiatry we're really trying to push clinicians to do more consistently. But I actually think at the end of the day, because of the points that Bonnie made about it being very difficult to interpret the findings and not really being sure how well this actually reflects the quality of care as an outcome measure, I think it actually works better as a process measure than it does as an outcome measure – at least in terms of what I actually think the benefits of using the tool are and how that's likely to affect quality. So, I remain actually interested in this measure. I don't think it's probably strong enough or widely applicable enough that it belongs in the Core Set necessarily, but I like the fact that a lot of state programs are using it and trying to generate more data for this. I do think there are hopefully going to be some more outcomes-based measures coming down the pipeline in

the next couple of years that I think probably will be strong enough to include in the Core Sets. But I think this one is probably not the right one right now.

Alli Steiner:

Thanks so much, David. That's a helpful perspective.

Let's hear from Anne Edwards next, please.

Anne Edwards:

Thanks, can you hear me?

Alli Steiner:

We can.

Anne Edwards:

Oh, great! So—

Alli Steiner:

Anne, I think we actually lost you. Can you try...? Oops, sorry, Anne. Can you try speaking again?

Anne Edwards:

Sure.

Alli Steiner:

Okay, I can hear you now – so if you wouldn't mind repeating what you said. Sorry about that.

Anne Edwards:

I was – it muted again, sorry about that. I really was talking about the impact and the ongoing crisis in mental health when we look at what we need to address in the adolescent population and even the child population. So, really interested in these measures that lead to outcomes and get us really into the space about thinking what do we do beyond the screen, and how do we support systems and measure the impact of that. Now, I actually came from Minnesota and practiced in Minnesota and was in leadership in the healthcare system, so I have experienced this as a clinician and as a leader. I also really do appreciate all the concerns that have been raised around feasibility and how to address that, which I think we often see when we tend to move from the process to the outcomes measures. But I do think I'm intrigued by potential other measures, but really want to encourage us to reach into this space so that we can move forward. The one thing -- and I should know this -- that I note – this focuses on depression and PHQ-9. Question 9 might indicate risk for suicide, but I didn't see anything in this measure that excluded that or addressed that. So, I guess if others have comments on that, would welcome understanding that more; but also want to just point out that as well.

Alli Steiner:

Thank you, Anne. I'm sorry, did I hear somebody come off mute to address that question? Okay, I wanted to ask if there is anybody from NCQA on the line who wanted to respond to that last question about inclusion of suicide in the measure. If so, please raise your hand; and we will call on you.

Can we unmute Lyndsey, please, Derek? Lyndsey, you should be unmuted.

Lyndsey Nguyen:

Hi, can you hear me?

Alli Steiner:

We can, thank you.

Lyndsey Nguyen:

Great, perfect, thanks – and thanks for the question. I appreciate the question about on the suicide. That's such an important topic and something that we've been wanting to include in our measures for some time.

But I will say that as far as addressing it specifically in this measure, it hasn't really come up I don't think during the development of the measure. If we're thinking about targeted intervention for suicide, like follow-up and things like that, I think that might be better as a separate measure. So, it wasn't specifically called out for this measure. This one is broader, and so that's why you see a longer follow-up period and assessment for that outcome over a longer period of time.

Does that help answer the question at all?

Anne Edwards:

Yes, thank you.

Alli Steiner:

Thank you so much, Lyndsey.

Just as a reminder, we'll have an opportunity to talk about gaps and priorities later today as well. So, we can continue to talk about that.

Let's call on Stacey Bartell next, please.

Stacey Bartell:

Hi, thank you. So, I'm on behalf of the AAFP. I have a couple of comments, and then I have personal comments of experience with this measure. So, while AAFP strongly supports outcomes measures, we do not like this measure in particular. What we find – a couple of things we just wanted to note which haven't been brought up before is although PHQ-9 is generally used for most people, it is not a required screening test for depression. In particular, for postpartum we use the Edinburgh; and there's another geriatric screening tool we use for depression in people who also have dementia that might be a little bit better. So PHQ-9 is not required for screening for depression. Sometimes we fall into it because it is in our electronic

health records, and so it's easier for us to use; but it's not the absolute required one that's used. So that's a struggle for people who opt not to use this measure.

In addition -- so on a personal note, I practiced in the Detroit area; and I used to work with a very large healthcare system. I was a physician champion for quality. This was one of our metrics in our Medicaid program for a long time, and we chased this metric like there was no tomorrow. We could not get it built properly into the electronic health record. We had -- our integrated behavioral health was not documenting in the same place in the chart that we were, so they weren't doing discrete datapoints for PHQ-9 scores. So, these patients -- while it looks good on paper as an outcome measure, to put it into practice it was just not practical.

I would say right now I work as a private physician, and none of our behavioral health use discreet datapoints or EMRs for charting their depression screening scores. So, I feel like the data is probably out there, but the data doesn't live in an easily accessible area; and that's the challenge. So right now, it's just not a great measure. It doesn't mean it couldn't become a better measure or be tweaked to be a better measure. It's just not great for support right now. Thank you.

Alli Steiner:

Thanks so much, Stacey.

Let's hear from Rich Antonelli next, please.

Richard Antonelli:

Can you hear me?

Alli Steiner:

Yes, we can.

Richard Antonelli:

Great, thank you. I can be brief. I also want to echo the fact that we are trying to prioritize measurable outcomes. This measure concerns me for the feasibility reasons that we've discussed. I won't go into more detail with that. But I would like to call out that one of the criteria that our Workgroup is supposed to consider when recommending new measures is the stratification, at least for those elements that are in the SHO. I think that's been a major accomplishment that we've been able to help improve the field around looking at certain elements with respect to that State Health Official letter. The measure steward is willing to do this stratification to bring in closer alignment with the SHO, but it hasn't been done yet. So, I just wanted to call that out. So, for me, that's a deficiency. Doesn't mean that we shouldn't continue to promote its use at a state level and especially focus on the feasibility. But for me this violates a real important principle, which I recognize we might not all agree is a must have. But I would like to argue that stratifiability should be critically important when we consider measures for addition. Thank you.

Alli Steiner:

Thanks so much, Rich.

Let's hear from Ben Anderson, please.

Benjamin Anderson:

Yes, I appreciate the opportunity to speak on this. I think for those who aren't aware, my work involves work on health systems from the patient or consumer perspective. So, with that in mind, really excited to see discussion around an outcome-based measure. I think that's a top priority for consumers, as we all want not just care and services but care and services that work. So really excited to see discussion around that. Also really excited to see thinking about how we might be able to better measure what's happening in the adolescent mental health space. There's a true crisis happening right now for teens across America. I really appreciated David's thoughts on the measure which I thought were incredibly informative and instructive, as well as the perspective of the folks at the states who have worked on this. Happy to hear that there will be continued focus at the state level and amongst providers in this space on how we might be able to perfect measuring outcomes on adolescent mental health in the future. But I think for all of the reasons that have been said, we won't be able to support this one. But happy that folks are thinking about it and that we're pursuing better options for the future. Thanks.

Alli Steiner:

Thank you, Ben, and thanks to all the Workgroup members that shared their perspectives. That was a really thoughtful conversation about that measure. Let's move on to the next slide, and we will have an opportunity for public comment.

So, if you'd like to make a comment about the Depression Remission or Response for Adolescents and Adults measure, please use the "raise hand" feature on the bottom-right of the participant panel to join the queue. We'll let you know when you've been unmuted, and please remember to state your name and your affiliation.

All right, I'll just give it another moment here -- not seeing any hands yet.

All right, well, why don't we move on to the next slide; and we'll continue on to voting.

So, for the Workgroup members, please log into Slido the same way you did yesterday. If you're having any technical issues, please message our team through the Q&A feature in the Slido panel or send us an email with your vote.

So, for our first vote for today, should the Depression Remission or Response for Adolescents and Adults measure be added to the Core Sets? The options are yes, I recommend adding this measure to the Core Sets, and no, I do not recommend adding this measure to the Core Sets.

Voting is now open. If you don't see the question, please try refreshing your browser. While we're waiting for the results to come in, we just wanted to remind everyone that the voting results you'll see on screen today are preliminary. Mathematica will do a careful review of the voting results at the end of each day to make sure that each eligible Workgroup member's vote was included and that no double votes were counted. If any of the voting results change as a result, we'll let you know during the wrap-up at the end of the day.

Thanks, everyone. We're just waiting for a couple more votes to roll in. We will check the list and let you know if we're missing any. Thanks.

Looks like we are missing Clara's vote -- if you can try to submit your vote again, Clara.

Okay, why don't we move forward and close the poll.

So, for the results, 6 percent of Workgroup members voted “yes.” So that does not meet the threshold for recommendation. So, Depression Remission or Response for Adolescents and Adults measure is not recommended by the Workgroup for addition to the 2027 Core Sets.

All right, I’m going to now pass it back to Deb to describe the next measure recommended for addition. Deb?

Deb Haimowitz:

Thanks, Alli. The next measure suggested for addition that the Workgroup will discuss is Initial Opioid Prescribing for Long Duration. Next slide, please.

Before we go into the details of this measure, I’d like to highlight that the 2026 Adult Core Set includes two measures related to opioid prescribing and/or treatment for opioid use disorder. The Use of Pharmacotherapy for Opioid Use Disorder measure assesses the percentage of Medicaid beneficiaries ages 18 and older with an opioid use disorder who filled a prescription for, or were administered or dispensed, an FDA-approved medication for the disorder during the measurement year. The Concurrent Use of Opioids and Benzodiazepines measure assesses the percentage of beneficiaries ages 18 and older with concurrent use of prescription opioids and benzodiazepines. Next slide.

Let’s now turn to the measure suggested for addition, Initial Opioid Prescribing for Long Duration. This measure is defined as the percentage of individuals ages 18 and older with at least one initial opioid prescription for more than seven cumulative days’ supply, and a lower rate indicates better performance. The Pharmacy Quality Alliance, or PQA, is the measure steward. This measure was suggested to replace the Use of Opioids at High Dosage in Persons Without Cancer, or OHD-AD, on the Adult Core Set. The OHD-AD measure will be retired for the 2026 Adult Core Set. The data collection method for the suggested measure is administrative.

The denominator includes individuals who meet all the following criteria: one or more prescription claims for an opioid during the measurement year and a negative medication history for any opioid medication during a lookback period of 90 days prior to each opioid prescription claim.

There are several notes clarifying the denominator. The prescription claims can be for the same or different opioids. For multiple opioid claims with the same date of service, calculate the number of days covered by an opioid using the prescription claims with the longest days’ supply when reporting the measure. For multiple opioid claims with different date of service, sum the days’ supply for all the prescription claims regardless of overlapping days’ supply when reporting the measure.

Finally, individuals may only be counted once in the denominator even if an individual has multiple lookback periods. Next slide, please.

The numerator for this measure includes individuals from the denominator population with over seven cumulative days’ supply for all opioid prescription claims within any opioid initiation period. An opioid initiation period is defined as a three-day period when the numerator is assessed. It includes the date of the initial opioid prescription plus two days. Since individuals may have multiple initial opioid prescriptions, there may be multiple opioid initiation periods. This means that an individual may have multiple opportunities to be numerator eligible.

PQA, the measure steward, noted that the measure allows for stratification by race, ethnicity, sex, and geography. PQA also confirmed that they currently stratify their measures by age and sex during their standard measure testing process but not race, ethnicity, and geography. PQA has piloted optional collection of race and ethnicity data in their most recent testing plans.

This measure was tested using Medicaid administrative claims data and enrollment data from four states. PQA was not aware of any state Medicaid and/or CHIP programs that are currently using the measure. PQA also noted that while the measure is specified at the health plan level, PQA measures can be -- and have been -- successfully applied to the state level.

Finally, PQA anticipates adding a cancer-related pain exclusion beginning in February 2025, which would be additive to the current cancer diagnosis exclusion.

The individual who suggested the measure noted as of 2017, Medicaid beneficiaries accounted for almost 40 percent of the approximately two million non-elderly adults with opioid use disorder in the nation. The individual also cited evidence demonstrating that greater duration of initial opioid exposure is associated with a higher likelihood of high risk and long-term opioid use, misuse, overdose, and other negative outcomes. The individual who suggested the measure emphasized that the measure would provide information on early-stage healthcare processes of opioid prescribing that are associated with high-risk and long-term opioid use, misuse, and overdose.

The measure was developed in alignment with the clinical guidance from the 2016 CDC Clinical Practice Guideline for Prescribing Opioids for Pain, which recommends that when opioids are used for acute pain, no greater quantity should be prescribed than is needed for the expected duration of pain severe enough to require opioids and that a supply of three days or less will often be sufficient and more than seven-days' supply will rarely be needed.

The individual who suggested the measure also highlighted that the measure does not penalize subsequent fills of greater duration but ensures appropriate follow-up and evaluation instead of potentially dangerous initial prescriptions. The measure steward further clarified that the measure was defined for retrospective population-level evaluation and is not intended to guide care for individual patients.

Finally, the individual who suggested the measure also noted that the measure responds to stated Core Set Workgroup desires for a more upstream measure focused on opioid-related quality. According to the individual, the measure is expected fill a gap in quality measurement that addresses opioid overdose risk. Next slide, please.

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'll now invite discussion about the Initial Opioid Prescribing for Long Duration measure from members. You may raise your hand if you wish to speak, and we will call on you; and you can unmute yourself when it's your turn.

Just to note, we are not aware of any states currently using this measure. But if there is a state that is and wants to share a state perspective, please feel free to raise your hand. Otherwise, all Workgroup members are welcome to chime in at this time.

Stacey?

Stacey Bartell:

Hi, I guess I'll get the conversation started. So, the AAFP leans towards support of this measure. I can just pick out a personal note in the practice in the state of Michigan where I practice that there's been a lot of work done in reduction of the initial prescriptions for pain meds to be less than seven days in over probably the last 5 to 10 years, and there's been a dramatic shift in opioid use in our state because of that. From dentists to surgical cases, it's been amazing to me how many people don't need narcotics after surgery now, particularly joint.

So, I think if states don't have this in place or haven't looked at this measure, haven't done that work, that this is a great measure to get that conversation started and certainly look at who is still not following this recommendation.

But in terms of – it's funny, when we talk about outcome measures, this isn't what you would necessarily call an outcome measure. But it's made a huge difference in outcomes, I think, for patients. So, it's just something we wanted to share. Thank you.

Alli Steiner:

Thanks, Stacey, and thanks for being willing to start off the conversation.

We'll go to David Kelley next, please.

David Kelley:

Thanks.

Here in Pennsylvania, we have not used this measure; but we have used something that's, I'll say, similar that we created and used in years that for some case management opportunities with our managed care plans. At the same time, I think our state legislature several years ago actually mandated reducing the number of days of opioids, especially when coming out of the emergency department. But, I mean, there's really good, interesting literature I think that is referenced in the materials submitted that looks at the use of opioids and even that one-time use in getting – unfortunately, getting folks on to more chronic use and sometimes inappropriate use.

So, I think this is an important measure. I do have a question for PQA as to whether or not buprenorphine is one of the meds that would be listed, or is that something that is excluded?

Alli Steiner:

Derek, can you please unmute Ben Shirley from PQA? Ben, you can go ahead.

Ben Shirley:

Can you hear me?

Alli Steiner:

Yes, we can.

Ben Shirley:

Great, thanks so much, appreciate the discussion.

Great question, David. So, this measure does not include medications indicated for medication assisted treatments. It does include methadone identified using outpatient prescription claims, but that would not be used for medication assisted treatments; and, no, no buprenorphine products are included in the measure. It's actually not listed directly as an exclusion; but within the value sets, there's sort of a footnote in the medication table. And the value sets contain no codes that would pull in those products.

David Kelley:

Okay, great, and that includes buprenorphine that's "formulated primarily for pain control" as well?

Ben Shirley:

That's correct.

David Kelley:

Okay, thanks so much.

Ben Shirley:

Sure.

Alli Steiner:

Thanks, Ben.

We'll hear from Lisa Patton next, if you could promote Lisa, please.

Lisa Patton:

Hi there. Can you hear me?

Alli Steiner:

Yes.

Lisa Patton:

Great, thank you.

I was very curious to hear from states on this one. I think there have been such multipronged efforts, as David and Stacey were saying, to really drive down prescribing, certainly those initial prescriptions. But I also think that this is a measure that we should look at adding because it

really signals the need for ongoing vigilance around this and just reminders that we do want to ensure that the prescribing stays within the guidelines and that those follow-ups do occur.

I especially like it because it's not suggesting that follow-up care should not be offered and that the cancer challenges will be addressed with it. But it also does signal that this is something we have to pay careful attention to as we move ahead. Even with the changing opioid epidemic that I think we're seeing; this remains an important issue to monitor.

Alli Steiner:

Thanks so much, Lisa.

Any other comments from Workgroup members?

Kim Elliott?

Kim Elliott:

Thanks.

I think that this is a topic that has been a high priority across states for quite a few years now, and states have implemented a lot of really good processes to really monitor utilization, question utilization, and those sorts of things, whether it's at the state level or at the managed care organization level. Measurement of it is really sometimes the key thing to really keep those efforts on track. What is measured gets done, so I kind of follow that philosophy on some of these types of measures. So, it might serve that purpose.

Alli Steiner:

Thanks, Kim.

Hannah Lee-Brown? Hannah, I think you are still muted, if you can try unmuting yourself. Yes, we can hear you now.

Hannah Lee-Brown:

Can you hear me?

Alli Steiner:

Yes, we can.

Hannah Lee-Brown:

Oh, good, thank you. I just wanted to add that I think it's worth calling out this is sort of standard practice in the Part D program. This type of an opioid edit is just standard in coding those types of programs. So, I think this measure does a really nice job of aligning quality in the government channels here. That's just worth calling out.

Alli Steiner:

Thank you, Hannah.

Just a reminder, if you have made your comment, please lower your hand.

Okay, I am not seeing any other hands. Last call for Workgroup comments before we move on.

Okay, why don't we move to the next slide, please.

So now I'd like to provide an opportunity for public comment. If you'd like to make a comment about the Initial Opioid Prescribing for Long Duration measure, please use the "raise hand" feature at the bottom-right of the participant panel; and lower your hand when you are done. We'll let you know when you've been unmuted. Just a reminder to please introduce yourself and give your affiliation.

Derek, can we please unmute Elizabeth?

Elizabeth Bentley:

My name is Elizabeth Bentley, and I am the National Pharmacy Director of Quality at Kaiser Permanente. I'm speaking in support of the measure. Really addressing the root causes of chronic opioid use is essential to mitigating the risk of long-term dependence. As mentioned previously, the measure fills a recognized need in opioid measurement and uncovers opportunities to reduce progression to chronic use.

When we prescribe quantities based on the duration of expected pain, that minimizes risk of addiction, dependence, and overuse. As we've seen, patients who continue to chronic opioid therapies will likely need support in the future with things like dose tapering and other unintended consequences that could be avoided through a more proactive reduction in initial quantities.

As an organization, we've been tracking performance on this measure; and we've continued to see performance improvement year over year. We believe it has additional performance improvement opportunities.

I also wanted to highlight the addition of this measure promotes harmonization across programs. The measure promotes a patient-centered approach, and failure to address initial causes of chronic opioid use does put patients at greater risk for long-term dependence and also the associated morbidity and mortality risks. Thank you for the opportunity to comment.

Alli Steiner:

Thanks, Elizabeth.

Derek, can you please unmute Eric next?

Eric Pittman:

Good afternoon, everyone. I'm Eric Pittman. I'm from the University of Mississippi School of Pharmacy. We're the DUR Medicaid vendors for Mississippi Medicaid. I'm on here to speak in support of this measure.

It aligns well with the opioid initiatives in place in Mississippi Medicaid. We already have a – we don't run this specific measure, but we have similar opioid guidelines in place, one specifically limiting initial opioid prescriptions for opioid-naïve patients to seven-day supply. So, this measure aligns well with what we do. We've seen significant reductions in opioid prescribing in Mississippi Medicaid, and we support this measure.

Alli Steiner:

Thanks so much, Eric.

Any other public comments before we move on to voting?

Okay, I'm not seeing any hands. Let's continue on to the vote. Next slide.

Okay, so for our vote, should the Initial Opioid Prescribing for Long Duration 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.

Just checking through the votes and making sure we got everyone's response. Just one moment, please.

Emily and Kai, if you could try submitting your vote. We were missing one of your votes.

We are still missing Emily Brown's vote. Emily, if you could try resubmitting your vote or reaching out to the team via Q&A. We did receive Kai's vote.

Okay, it looks like Emily's not on the call at this moment. So, let's close the vote, please.

Okay, so for the results, 90 percent of the Workgroup members voted "yes." That does meet the threshold for recommendation. The Initial Opioid Prescribing for Long Duration measure is recommended by the Workgroup for addition to the 2027 Core Sets.

So, thanks, everyone, for that great discussion. We're now going to head into a break, and we will meet back here at 1:00 p.m. Thank you.

BREAK

Alli Steiner:

Hi, everyone, welcome back from the break. Now I'd like to turn it over to Talia to lead the discussion of the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit measure.

Talia Parker:

Thanks, Alli. We will now review the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visitmeasure.

The 2026 Child Core Set includes one measure related to oral evaluation for young children, the Oral Evaluation Dental Services measure, also known as OEV-CH. OEV-CH measures the percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.

Let's turn now to the measure suggested for addition: Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit. This measure is defined as the percentage of enrolled children aged 6 months through 5 years who received a comprehensive or periodic oral evaluation with a dental provider within 6 months following a medical preventive service. The measure steward is the American Dental Association on behalf of the Dental

Quality Alliance. This is a process measure that uses the administrative data collection method, and it is not suggested to replace a current measure on the Core Sets.

The denominator is the unduplicated number of enrolled children aged 6 months through 5 years with a medical preventive service visit between July 1st of the year prior to the reporting year and June 30th of the reporting year. The numerator is the unduplicated number of enrolled children aged 6 months through 5 years who received a comprehensive or periodic oral evaluation as a dental service within six months following a medical preventive service.

The technical specifications for this measure include stratification by age group for ages 6 months to less than 1 year, ages 1 through 2, and ages 3 through 5. The measure steward indicated that stratification of the measure by additional factors is feasible, as demonstrated by the DQA Oral Health Dashboard which reports all measures stratified by age, race and ethnicity, sex, and geography among other characteristics for which there is sufficient data completeness.

Measure testing was conducted using Medicaid and CHIP enrollment and claims data contained within the Transformed Medicaid Statistical Information System, or T-MSIS Analytic Files, also known as TAF, from CMS using data for the following states: Alaska, Delaware, Michigan, New Mexico, North Carolina, and Washington. This measure was approved at DQA's June 2024 Membership Meeting. Consequently, the measure has not yet been implemented by state programs.

This measure is included in DQA's online, interactive, oral health dashboard for reporting dental quality measures using T-MSIS data for all 50 states plus D.C. The DQA Dashboard is available at the link on this slide.

The individual who suggested the measure noted that delays in the first dental visit increased the likelihood of early childhood carries and consequent adverse effects on child health and quality of life. Yet most Medicaid beneficiaries do not have a visit with a dental provider. For example, according to Medicaid EPSDT reporting among Medicaid-enrolled children, 79 percent of 1- to 2-year-olds had a medical visit in Federal Fiscal Year 2021 compared with 26 percent who had a dental visit. The high rates of medical visits in early childhood represent an opportunity to connect children accessing the medical system to dental care.

The individual who suggested the measure indicated that measure testing results demonstrate an overall performance gap, as well as variation in performance between programs. They argued that Medicaid and CHIP programs and their participating providers can directly influence improvement on this measure and suggested that if added to the Core Sets, the measure could be used to assess Medicaid and CHIP program performance and progress over time.

The individual who suggested the measure asserted that this measure would add value to the Core Sets because there are currently no measures on the Core Sets that support improvement in the integration and coordination of care between medical and dental care systems for children. They mentioned that the measure focuses on early childhood where the impact on oral health can be the greatest by preventing early childhood carries, establishing children with a dental provider, and laying the foundation for ongoing dental care.

With that, I'll pass it back to Alli to facilitate the Workgroup discussion.

Alli Steiner:

Thanks, Talia.

So, we'll now invite discussion about the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit measure from Workgroup members. You may raise your hand if you wish to speak, and we will call your name, and you can unmute yourself. Please remember to say your name before making comments and lower your hand when you are finished.

I'll just note that we are not aware of any states on the Workgroup who are currently using this measure, so any Workgroup members are welcome to make a comment.

Let's see, can we promote Angela, please.

Angela Filzen:

Good afternoon. Can you hear me, okay?

Alli Steiner:

Yes, we can.

Angela Filzen:

I'm Angela Filzen from Mississippi. I'm a general dentist, and I just want to start by thanking the American Dental Association on behalf of the Dental Quality Alliance for recommending this measure, which I support. I've been a general dentist for over 20 years and have worked in community health center settings, which I currently work for one now in Mississippi, but also formerly the state dental director for the State of Mississippi.

We understand the importance truly of inter-professional collaborative practice. We really appreciate our medical providers and know that we cannot irradicate early childhood carries without working across the board. So, I really support this measure because it strengthens our relationship and the cross-linkages of care that we can provide to children. We know that dental decay is preventable if you have early diagnosis and risk assessments and all of those care planning attributes.

In a state like Mississippi that experienced a child losing his life to dental care reasons in 2007, I know we heard a lot about Deamonte Driver; but actually, in Mississippi, we had something similar happen. So, these types of systems' inclusions really do afford us the opportunity to work across the board because even in 2025 we still have people who don't correlate the importance of baby teeth and just good oral health to overall health outcomes.

So, we know that delays in the first dental visit can be associated with increased dental carries, treatment needs, and dental procedures. So really excited about the opportunity for this recommendation to move forward and to support it wholeheartedly. Thank you.

Alli Steiner:

Thank you so much Angela.

Sarah?

Sarah Tomlinson:

Can you hear me?

Alli Steiner:

Yes, we can.

Sarah Tomlinson:

I agree with Angela. I just want to -- I work for Dental Medicaid in North Carolina. But before doing this, I was state dental director for North Carolina; and I've seen what she's seen. Regular well-child visits that infants and toddlers have are opportunities for dental referrals. At those visits, medical providers can guide parents and caregivers in proper dental care and prevent many dental problems by referring them early to a dental home.

To prevent dental problems, the American Dental Association has promoted a message of a first dental visit by age 1 for decades. Having medical providers underscore the importance of a dental visit at an early age improves follow through of the dental referrals. North Carolina learned through its Into the Mouth of Babes program, which was started by family physicians who were concerned about the poor oral health of their very young patients, that parents are more likely to take their child to the dentist after a referral from their medical home. So, I believe that adding this measure will begin to show the power of referral to a dentist by a medical practitioner, and I support adding this measure to the Child Core Set. Thank you.

Alli Steiner:

Thanks so much for your comments, Sarah.

Let's hear from Chimene next, please. Can we please move Chimene up to a panelist.

Chimene Liburd:

Good afternoon, Chimene Liburd. I support this measure. However, what we're seeing in D.C. is the lack of access to dental providers for a number of reasons. I convened an advisory group because one of the complaints was reimbursements and just the inability to do the work that was needed based on the reimbursement. So, there are a lot of providers that are not accepting Medicaid; and those that are, the wait times are long for children to get in.

So, while I support this measure, I think my concern is that if there is a referral done, how do we measure the outcome of that referral? While a referral may have been made, did the child get in to see the provider? That, to me, would be the best way to assess them getting care by a dental provider. I don't know if I have the right way to kind of explain or describe how to potentially use this in a way that is meaningful. I think it ends up being data that is not going to be useful if patients/beneficiaries are not able to access these dental providers. So perhaps a different type of measure or an outcome measure would need to be created in order to better serve the desired outcome of getting children in to see a dental provider.

I think I'm struggling with really being able to understand what this truly will do if that referral is not acted upon. Thank you.

Alli Steiner:

Thank you so much, Chimene.

I thought I saw a hand from Hannah. Hannah, do you have a comment you wanted to make?

Hannah Lee-Brown:

Yes, thanks. Can you hear me?

Alli Steiner:

Yes, we can.

Hannah Lee-Brown:

Oh, hello? Okay, great. I'm Hannah Lee-Brown; and actually, the speaker right before me said very much in line with what I was thinking. I was just very curious. I have a question for the states on the line what the access experience with dental providers in the states was like, if there were any challenges or issues from an access lens, either shortage of primary care dentists or issues with scheduling for Medicaid recipients.

So, I'd be curious if there are any other states that can offer a perspective there, if they're having the same sorts of challenges that were just described.

Alli Steiner:

Thanks for that question, Hannah. I see a lot of folks with their hands raised. I'm going to ask – let's see – I'm going to look for some of our state folks here.

David Kelley, did you want to either respond to that question or make a separate comment? Go ahead and feel free to do either.

David Kelley:

I can certainly respond to that question, and then I have a couple comments.

So, I think dental access is very – of vital importance; and I think post-pandemic we've seen a lack of not just dentists but some of their support staff, and that has led to access issues. I think within Pennsylvania, we're working very closely actually with the ADA on a multistate project to really enhance our networks.

One of the challenges that we see is, again, referral to children at an early age. We're big advocates of this – that that first tooth erupts, a child should see a dentist. Some of our dental providers are like, "Why are you sending these children to us?" So that is a barrier in and of itself. But I think over the years, more and more of our dentists have come to realize what the recommendations are; and they're more willing to do that. So, it's not just a general access issue, but then it's for this very young age band. It's an access issues too for our current dental providers, and it's an educational opportunity.

Under EPSDT, we require that our medical providers refer their children to dentists. As part of the EPSDT visit, we do have some combined incentives for both medical providers and for dentists – including getting them in early for preventive services.

One comment, usually there's information about what's currently on the Core Set; and I didn't see that presented. I just wanted to know what is the difference between this measure and one of the other dental measures that's already on there. It seems like there would be some overlap between this measure and the oral evaluation of dental services. Because there is an age – there are age bands there, and that includes a lower age band. So, to me, this seems like it

would be redundant. So, I'll comment on that, and maybe ask the measure steward to comment on the current versus this new one and whether or not there's redundancy because that's the last thing we need is redundancy.

Then I have a question about this measure. Is there a requirement that there's like some type of claims history that a medical provider has been seen first, and then there's a referral and a claim for the dental visit? I'll put my hand down and let folks hopefully respond to that.

Alli Steiner:

Thank you, David. So, this measure being suggested for addition looks at the link between the primary care and dental and requires that medical visit to happen first. But I'd love to hear from DQA to provide any additional insight and also respond to that last question you had.

So, let's see – Derek, can we please unmute Jill Herndon?

Hi, yes, we can hear you.

Jill Herndon:

Great, well thank you so much for the opportunity to clarify; and that's a great question about the potential overlap between this measure and the existing oral evaluation measure.

One of the first things that the DQA evaluated was the benefit of this measure given the existing oral evaluation. This was actually developed based on requests from the stakeholder community for a measure that would focus specifically on those children seen in a medical setting but without a dental visit targeting an improvement opportunity on the medical side to connect children to dental care. That's why it also focuses specifically on the youngest children, who are least likely to have established care with a dental provider combined with the evidence that demonstrates that early risk assessment, prevention, and care planning help prevent early childhood carries, which has those detrimental consequences that Dr. Filzen and Dr. Tomlinson described.

So, it is complementary to the current measure, but also distinct and targeted, a need that the DQA was clearly hearing from the community.

Regarding the timing, yes, there is a medical preventive service visit identified as the index visit; and that's the first. If there's more than one during the year, which is common with young children, it's the first one because the goal is to get children in to seeing a dentist sooner rather than later. And then looking for an oral evaluation with a dental provider after – within the six months after that index visit. That's after excluding children who had an oral evaluation in the six months prior to the medical visit – so really trying to focus on those children who have not had a connection with the dental care system.

David Kelley:

Thanks, that's very, very helpful and really see the value, especially of that, in getting those children in that have not had a previous dental visit. I see really great value to that. Believe me, in Pennsylvania we're big proponents of early and often in getting those children in. I think there's especially key opportunities in like a lot of FQHCs have both medical and dental, and it's a huge, missed opportunity at times when we see our well-child visits in the 80-some percent,

close to 90 percent, in some age bands; and we see our dental in probably the 30 to 60 percent. So, it is an opportunity.

Thanks so much for that clarification.

Alli Steiner:

Thanks, David.

And thanks, Jill, for being here to provide that additional context.

Let's go to Angela Parker next, please.

Angela Parker:

I am with Kentucky, and we most definitely see the value in this. As we know, dental care is health care; however, we do have challenges as requested with access. We have a dental technical advisory committee that meets every other month and discusses the woes of, number one, getting patients in and keeping their appointments and/or getting paid appropriately.

Now, obviously we want our children to get in and get that dental visit. I do see the value, as David mentioned, in the primary care connection. I think you'd see that more in FQHCs but not necessarily to be at the primary care. I mean, if they're doing a well-child visit, they should be looking in a child's mouth and then doing that referral if they notice issues or not. So, I do see some redundancy as also has been mentioned. In general, I do support it. I think it's just – there's some challenges in getting that into place.

Alli Steiner:

Thanks so much, Angela.

Katherine?

Katherine Leyba:

Can you hear me? I'm not sure if you can hear me.

Alli Steiner:

Yes, we can. Thanks for asking.

Katherine Leyba:

Oh, great, thank you.

Hi, I'm Katherine Leyba. I'm with New Mexico Medicaid.

I also wanted to give comment how, yes, this is a very – I mean, we do see the value in a measure like this, but New Mexico does struggle with network. We have had the dental measures in our managed care organization as performance measures and tracking measures over the years. In recent times, we've seen a decline in the dental visit outcomes; and it's mainly due to access. We do not have a big network of pediatric dentists, and it is a struggle for us. It's a valuable measure; however, I feel that we would have difficulties, and the outcomes would not

really produce the effort of the primary care provider. It would actually show the decline, and it's mainly due to network.

Alli Steiner:

Thank you so much for that comment.

Let's go to Anne Edwards next, please.

Anne Edwards:

Thanks, can you hear me?

Alli Steiner:

Yes, we can.

Anne Edwards:

Great, I won't repeat what others really have been highlighting around access. I want to say that from a pediatrics perspective, we really value the partnerships we've long had with our dentists and pediatric dentists. Oral health is really a priority and something that is emphasized as we consider preventive care. Yet these measures really – the level of accountability, it's been a struggle on the clinician level to actually have access to dental providers. Certainly, there are some opportunities and some innovative ways at the community level and state level. Work has been done to address the issue of access, including a care coordination effort that really provides a handoff and ability for the primary care provider to know that the dental appointment was complete; and that, apart from access, is also a real challenge.

So, while this is well-intentioned, I worry about the systems and who will be held accountable – especially if this were to be in a pay-for-performance program. So would encourage us to continue to think about how we move the system along to an improved system. Thanks.

Alli Steiner:

Thanks so much, Anne.

Kim Elliott?

Kim Elliott:

Yes, this is a very interesting measure; and I think it's a really good measure. One of the things we always look at when we do compliance reviews for EPSDT is whether providers are – PCPs are referring children to dental providers. It's one of the elements that we look at for compliance. We also know that when PCPs are recommending a care service, the families pay a lot more attention to that than if their health plan sent them a mailing or something like that. That's really just an important piece of it. We do know that access continues to be a real challenge, particularly in the really young age groups.

Then the other thing I think that creates a little bit of a barrier from this measure perspective in really making improvement is dental is often carved out of the health plan. So, access to who is receiving the services could be a little bit delayed or maybe not available at all depending on what data they get from the state Medicaid agencies on dental utilization. So that makes it a

little bit more challenging sometimes to really focus appropriate interventions on, or in the areas providers perhaps that you would really want to encourage some improvement.

Then the other thing I would say too is there are other really good opportunities, such as when PCPs are applying dental varnish in the pediatric practice, the family practice office. It's a great opportunity for them to make those connections and really do that referral. So, a lot of good with this one.

Alli Steiner:

Thanks so much, Kim.

Stacey?

Stacey Bartell:

Thanks. Interestingly, my comments follow Anne and Kim's exactly in that on behalf of AAFP, from a primary care perspective, we would not want the primary care provider held responsible for this measure because a lot of states have severe deficiency in their Medicaid dental networks. Although we can "make the referral," that's not clearly what's being measured here. What's being measured is the actual dental appointment following the primary care appointment, not was the referral made. So, I just want to make sure we're measuring the right thing and what the intent is.

The second thing is back to what Kim just noted is that we did in primary care get training on that Smiles – I don't even remember the name of the program – the Smiles program where you do an early oral health exam and apply the varnish. I'm curious, it does not – I wanted to ask the dental providers on the call – it does not appear does that that meets the criteria for a dental visit. They still needed to be referred to a dental provider. So, I wasn't sure when we were trained in that Smiles – whatever that Smiles program was, is that supposed to take the place of a dental visit? That's supposed to just help ease the dental visit along, or that's just one more person looking at the teeth?

Because I think that that's how we were trying to improve access in our state was by getting our providers trained in that. But mainly, we just didn't want the primary care provider held responsible for a health-system-, health-plan-, state-level issue that is not related to us. So, while referrals are nice and we agree with the conversation and if we send them, that doesn't always get the service done.

Alli Steiner:

Thanks, Stacey.

Jill, are you able to respond to that question about what counts for an oral evaluation?

Derek, can we unmute Jill Herndon, please?

Jill Herndon:

Hi, yes, for the purposes of the measure, it is specifically a visit with the dental provider. There are other measures that look at topical fluoride, for example, delivered through both the dental and the medical systems of care. But this is specifically focusing on the clinical guidelines,

including guidance from the American Academy of Pediatrics, that children do establish care with a dental provider by age 1. So, it is focused specifically on that.

But I thought I also heard the question as being a clinical one to dental providers, so I can't speak to that aspect of it from a dental clinical perspective. So, there may be somebody else on the call who can better address it from that perspective. Thank you.

Alli Steiner:

Okay, I see Angela Filzen's hand raised. Angela, are you able to respond to that comment? Or if not, please feel free to make the comment that you were planning to make when your hand was raised.

Angela Filzen:

Thank you. Yes, I can respond.

The Smiles for Life curriculum is a great curriculum; and we support that as far as non-dental providers getting more information around various modules -- oral exams, geriatrics, kids. So, the modules are created to share information and to further train medical provider teams on different oral health matters. So that when you're doing your wellness exams, you have that preliminary information and knowledge to do an assessment; but it still leads to a definitive referral to the dentist for further treatment, diagnosis through x-rays and those types of things. Because initially through that wellness exam, you just want a visual oral screening to see if there are any urgent issues, any incipient decay as it relates to the teeth, any carries that you can visibly see – those types of things –and then that soft handover to the dental provider.

So, I hope that answers the question about Smiles for Life. We love the curriculum. It does support kind of integrated work and looking at what you need to look at and know how soon to refer, if it's an elective or urgent type of need.

The other thing that I did want to say along those lines is with my work with the State Department of Health in Mississippi, I do appreciate the comments around access to care. From my view, this one is about access to care but more so utilization. As a medical provider who would do the fluoride varnish application, of course that is to help prevent carries in children. However, definitive treatment is needed with that soft handover to the dentist. What we did in our state is – I believe someone else mentioned this – is work with care coordinators.

So, in my department, I actually hired a dental care coordinator who would work with our WIC program. We now have a program called Healthy Moms, Healthy Babies, which is for pregnant moms helping them to understand the importance of taking care of her teeth but also where to get the baby in. Then also with our Head Start and our FQHCs. So, we know that it's easier in systems where you have multiple professions, like at FQHCs. However, we did work with our organized dentistry entities to provide what you're kind of speaking of. Who are our Medicaid providers? Where are they located by county? And to assist with getting patients and their families in to see a dentist. Those are the types of linkages to care and networking opportunities that really can be supported if we're able to show through measures as such the utilization is a challenge. Because we want teeth to be seen, and we want for our medical providers to do that soft handover; and we do appreciate and understand the difficulty in that.

But not landing in the dental chair to receive a further evaluation that includes x-ray, that's more anticipatory guidance, is really detrimental to this age group. So, I hope that helps to answer and to share some opportunities.

One last thing I will say is that with our initiatives in Mississippi, we also were able to partner with our local – our state, rather, insurance plans. So those providers that will do a wellness visit and maybe they weren't doing as many and had some challenges with the oral part, the oral screening part, then we came in as a state department to assist those providers and help give them the support that they needed. Then also, the insurance companies allowed us to actually provide literature and information to families through their program.

So, there are a lot of opportunities that can be utilized to try to connect the dots, as I hear from some states here that the access to these providers is problematic. But there are some ways to help better those connectivity points. Thank you.

Alli Steiner:

Thank you so much, Angela. Those were really helpful examples.

Let's go to Rich Antonelli next.

Richard Antonelli:

Yes, can you hear me?

Alli Steiner:

Yes, we can.

Richard Antonelli:

Great, so a couple of opening points. Oral health is extremely important, and the progress that we've seen actually with measures coming through our Workgroup in the past few years is truly one of the most inspiring parts of the engagement that I've had; and we need to do more.

Second, whenever I look at measure specifications – and for those colleagues that know me and what my passion is, if you use the terms "care coordination" and "care integration," you're going to get my attention. And I was thrilled to see that. But here's the issue I have with this measure. Fitness for purpose – in fact is this measure looking at the gap between primary care and then making a referral to the oral health providers, or is it telling us essentially what we kind of already know? The proverbial elephant in the room, if not the nation, is we don't have enough Medicaid providers for oral health. It's even worse on the adult side, but I'll restrict my comments to the pediatric population.

So, I question the actionability. Is this an access measure of timely access to oral health providers, or is it designed to get primary care providers to do a better job following the guidelines that have been in place for quite some time between AAP, AAFP, et cetera, et cetera? That for me triggers – I was appreciative when Anne Edwards mentioned the accountability. I'm not sure how much upside there is for pediatric – I'll speak to that population since I'm a pediatrician myself – but I would assume that there's probably some resonance with our family medicine providers, which is – is it that we're not making the referral, or is it that there isn't enough capacity in the system for oral health providers on the pediatric side?

So, I am confused about what the point of this measure is and whether, as configured, it is fit for purpose.

Alli Steiner:

Thanks so much, Rich.

Let's go to David Kelley.

David Kelley:

Thanks, just a question on the measure. The definition of dental provider, does that include public health hygienists or other dental extenders that would be either under the direct supervision of a dentist or if they're independent – different states have different rules? What is the definition of a dental provider? Because I think that might be helpful.

Alli Steiner:

Thanks, David.

Do we still have Jill on the line? If so, please raise your hand. Can we unmute Jill, please, Derek?

Jill Herndon:

Hi, thank you for that question. The DQA has followed the same guidance it followed for the CMS EPSDT reporting, the federal regulations, by or under the supervision of a dentist. So, it aligns with the way it's defined for the CMS EPSDT reporting.

David Kelley:

Okay, thanks.

Alli Steiner:

I just wanted to ask if anyone had a response to the questions that Rich raised before we move on.

I'm not seeing any new hands. Okay, well thanks, everyone, for that very helpful discussion. Let's move on to the next slide, please.

We'd like to now provide an opportunity for public comment. If you'd like to make a comment about the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit measure, please use the "raise hand" feature at the bottom-right of the Participant panel to join the queue, and lower your hand when you are finished. We will let you know when you've been unmuted. As a reminder, please do state your name and affiliation.

First up we have Chevon.

Chevon Brooks:

Hello, how are you? Can you hear me?

Alli Steiner:

Yes, we can.

Chevon Brooks:

Excellent, okay, thank you so much for the opportunity. I'm Chevon Brooks. I am a pediatrician. I am representing the American Academy of Pediatrics as the Chair of the Executive Committee on the section of oral health. In addition, I'm a pediatrician in the state of Georgia. I'm also a part of the Georgia Chapter's AAP Oral Health Task Force.

I really appreciate the opportunity to comment. I do support this Child Core Set measure. As has been stated, AAP and AAPD, we both support children being seen by age 1 and every six months after the first eruption of a tooth. I think this measure will help with us as far as our medical and dental integration. We're continuing to do work as far as medical and dental integration. Our section in particular is having some different workgroups trying to get interdisciplinary people from across the country try to come to streamline that as far as how we can do that in different states.

However, I do think that this measure again reinforces that we do want to have comprehensive care. In order to have that, pediatric dentists and pediatricians do need to be working collaboratively. Yes, as part of again what's recommended for both our organizations, yes, we're all doing oral examinations, and you know, pediatricians – I think I heard someone mention the Smiles for Life. Many of us use that curriculum. Many of us are very well-versed as far as the oral examination and providing anticipatory guidance as far as oral care and fluoride varnish, et cetera.

However, a part of those recommendations still punctuate that we should be referring to a dental home and that the child should be following up in a dental home every six months. So, I do feel like this measure could focus on connecting children to dental providers in order to include that comprehensive diagnosis and risk assessment and care planning and, again, strengthen that relationship between the pediatricians and the pediatric dentists. So again, I'd just say I support this measure. Thank you so much.

Alli Steiner:

Thank you so much, Chevon.

Jim Crall?

Jim Crall:

Yes, can you hear me?

Alli Steiner:

Yes, we can.

Jim Crall:

Oh great, thank you. Jim Crall, I'm a Professor Emeritus at UCLA School of Dentistry, former member of the Core Set Workgroup, and one of the ADA's representatives on the Dental Quality Alliance.

I'd like to speak in strong support of the addition of this measure to the 2027 Child Core Set. I think it would be the first Child Core Set measure to support improvements in integration, coordination of care between medical and dental systems. It focuses on young children, which published evidence shows a critical period for reducing early childhood carries, improving care experience, and reducing costs of care. It aligns with recommendations from the Academy of Pediatrics, APHA, the Academy of Pediatric Dentistry, the ADA, on early establishment of a dental home, especially for higher-risk groups. It aligns with the CMS Medicaid and CHIP Oral Health Workgroup initiative that emphasizes preventive and minimally-invasive oral health care. The testing done using T-MSIS data clearly shows major feasibility and gaps in performance.

What I'd like to really comment on is experience I had while I was at UCLA working with about 20 federally qualified health centers in LA, where we worked to develop a quality improvement collaborative focusing on the medical/dental integration for preschool age kids. That was published in Health Affairs back in about 2016.

Expansion of that work subsequently to the state level through work on the Medi-Cal program prompted additional work to develop a state registry to help track referrals from PCPs to dental providers on a broad scale, given that the EHRs oftentimes don't facilitate any type of recording of activity across medical and dental systems.

I actually really think that this proposed measure would allow states to assess the extent to which such referrals are taking place and help develop QI initiatives to address gaps in performance. There have been some limited examples where states have used incentives and rewards to improve performance in this area. Looking ahead, I think that adoption of this measure would stimulate the incorporation of data gathering into EHRs that looked to support care coordination across multiple sectors.

For all of those reasons, I encourage the Workgroup to recommend addition of this measure to the 2027 Child Core Set.

Just as one final comment based on the earlier discussion by Workgroup members, none of the dental Core Set measures that we have can be improved without an adequate network. So, I don't see necessarily why that should be a barrier for this particular measure. It's incumbent and inherent, I think, in all the measures to highlight where gaps exist and to help focus efforts to address those gaps. Thank you.

Alli Steiner:

Thanks so much, Jim, good to hear your voice again.

We do have a number of additional hands raised. So, I'd just encourage everyone to try to keep their comments as brief as possible so we can make sure to hear from everyone and to try to focus on points that have not been previously raised.

So, we'll go to Julie next, please.

Julie Reynolds:

Am I being heard?

Alli Steiner:

Yes, we can hear you.

Julie Reynolds:

Thanks so much.

My name is Julie Reynolds. I'm a faculty member and public health dentist at the University of Iowa College of Dentistry and also want to disclose that I'm the current Chair of the Dental Quality Alliance.

I'm speaking in support of the measure because I think it would equip state Medicaid programs with actionable data to improve the integration of medical and dental care for young kids and to develop systems that support that integration.

To the question of overall dental care access for this population and the ability to find a dental provider that takes Medicaid, this challenge is one of the reasons that a measure like this is so important. Data for this measure could equip state Medicaid programs to develop referral infrastructure, improve care coordination, and develop incentives for dental providers to accept very young kids with Medicaid.

Another provider level – it's conceivable that a facilitated referral from a physician coupled with support systems, like care coordination and payment incentives for participation, could make a dentist more likely to accept a young child with Medicaid in their practice.

The measure will tell us which children are able to access primary medical care but not dental care and so would help state Medicaid programs to take actions to try to close that gap.

To the question of potential redundancy, the oral evaluation measure gets at access to dental checkups for the full child Medicaid population but doesn't get at the opportunity for integration with medical care. So, the measures are complementary to one another and not redundant.

Lastly, because Medicaid programs have access to both medical and dental administrative data, they are uniquely positioned to measure this important indicator of integrated care; and it's likely that this measure will provide actionable information for the state or their managed care plans to develop better systems for referral tracking, care coordination, and communication between medical and dental providers.

Thank you so much for the opportunity to comment; and again, encourage the Workgroup to vote "yes," to include this measure.

Thank you, Julie.

We'll hear from Chelsea next.

Chelsea Fosse:

...the staff at the American Academy of Pediatric Dentistry, and I am a public health dentist as well.

Thank you so much to the Workgroup for the very robust and thoughtful discussion. Many of those concerns and comments have been discussed too at the dental level. I do want to share that our leadership here at the American Academy of Pediatric Dentistry, AAPD, is very

supportive of moving forward with this measure. It was really interesting to hear some of the concerns regarding the blame game of what this could lead to.

I mean, really our read is that it would illuminate the shortcomings on the dental side, that it would shine a light on areas for improvement as has been mentioned by other commenters here.

As Dr. Crall mentioned too, right now there does not exist reasonable alternatives to look at this issue of referral. Our coding, our HIT systems, don't really have a way of measuring the successful referral. Definitely agree that this would demonstrate areas for better connection between sites of care, whether that's FQHCs, school programs, private practices – that there could be a lot of really good activity generated there.

I also want to thank Dr. Bartell on the Workgroup and Dr. Brooks from AAP for the comments regarding oral health assessment, Smiles for Life curriculum. While dentists are endlessly grateful to medical colleagues for their attention on oral health, as Dr. Brooks said, there definitely needs to be a connection to comprehensive oral health care.

I want to underline too what Dr. Crall mentioned earlier – that this is very much in line with the recommendations from the CMS Medicaid and CHIP Oral Health Initiative recommendations on minimally-invasive and preventive services.

Lastly, I'll just state that we strongly agree with the inclusion of this measure in the Core Sets for the main reason that it will be actionable at the state level for looking at opportunities to strengthen the connection between medical and dental care. Thank you so much.

Alli Steiner:

Thank you, Chelsea.

We'll hear from Chris next.

Chris Farrell:

Okay, I'm Chris Farrell; and I am the representative for the American Dental Hygienists Association. I am a public health dental hygienist. I'm also the Oral Health Program Director for the Michigan Department of Health and Human Services. But I am representing ADHA.

My quick comments are that we support the proposed measure since it illustrates medical home components of family-centered care and effective care coordination. From a public health view, this measure may promote prevention campaigns of both medical and dental offices to provide increased oral health education awareness around the importance of early dental care. I support all the other comments; and, like I said, my comments are short and sweet. I'll let others speak.

Alli Steiner:

Thank you so much, Chris.

We'll hear from Shillpa next.

Shillpa Naavaal:

Are you guys able to hear me?

Alli Steiner:

Yes, we are.

Shillpa Naavaal:

Okay, perfect. This is Shillpa Naavaal. I am representing American Association of Public Health Dentistry. I'm a professor at the School of Dentistry, Dental Public Health field and a health services researcher.

Amazing discussion and really robust. I'm glad to see everybody so involved and trying to make it the best possible. I would strongly support this measure for all the given reasons that previous speakers and commenters have mentioned and kind of again highlight that we really don't have any dental/medical integration measures. So, I think this will be one of the first ones, kind of paving the way.

At the same time from the research standpoint, a few -- many of them already have kind of mentioned the importance of it and having a dental home at an early age as how can that be really making a gamechanger for so many kids who otherwise would not have that. Having this measure, again, kind of will allow for more things to happen without which they would not. So, I think, again, to wrap it up, kind of really strong support for this measure and hoping that this will lead the way for new things to happen. Thank you.

Alli Steiner:

Thank you so much, Shillpa.

Ramona?

Ramona English:

My name is Ramona English. I am a public health dentist and Chief Dental Officer for a federally-qualified health center. However, I'm here today to provide comments on behalf of the National Network for Oral Health Access as Chair of its Quality Committee and also as a board member.

For over 30 years NNOHA has provided technical assistance to safety net oral health programs, reaching beyond its 5,500 members to over 19,000 oral health professionals across more than 1,100 health centers nationwide. In 2023 alone, NNOHA members cared for over 6 million patients across over 20 million dental visits, reflecting a continuous commitment to increase access to high-quality oral health care for all.

NNOHA strongly supports the addition of the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit, and we do support this measure as being the first Child Core Set measure to explicitly support the coordination between medical and dental and targeting early childhood carries.

Not to repeat myself, I'm going to speak a little bit more about the feasibility and actionability in the community health centers. As you all know, young children are far more likely to have a medical visit than a dental visit in the early years. Among Medicaid-enrolled 1- to 3-year-olds in 2021, 79 percent had a medical visit while only 26 percent had a dental visit. If we are to

prevent the disease burden, we need to ensure this early access. As AAPD, ADA, the first dental visit should take place before the first year; but there are big gaps in meeting that goal.

We've had NNOHA members over the years participate in integration of oral health into primary care practice learning collaboratives in perinatal infants' oral health quality improvement projects. We were able to increase that percentage of 1- to 3-year-olds up to 60 percent, so from 26 percent up to 60 percent, through innovative initiatives such as same-day medical/dental visits for the 0- to 3-year-olds, embedded medical providers in dental practices, utilization of community health workers for outreach and care coordination, along with leveraging integrated electronic health systems to optimize referrals and scheduling.

To speak a little bit about the provider network for Medicaid patients, there are some promising practices out there -- the Washington State ABCD program, also San Francisco's Dental Transformation initiative. They have demonstrated that it's possible to expand a network through incentives and training, for example, and it would be beneficial for similar efforts to expect.

I encourage the Workgroup to vote "yes" on adding this measure. Thank you very much.

Alli Steiner:

Thank you, Ramona.

John?

John O'Malley:

...oral health, a think tank supporting oral health for all Americans, where I'm the manager of Data Science.

Very strong support of this measure for many good reasons spoken previously. I want to add just a little more flavor in ways that we haven't really discussed yet. We feel this measure has a low reporting burden and would be quite feasible to calculate at the program and plan level, especially someone whose last job was at a dental insurance company reporting these measures to the state. The measure specifications are pretty simple, the code set is pretty simple, and what you need to know about how to calculate it isn't too burdensome for anyone. Thank you.

Alli Steiner:

Thanks so much, John.

Thanks so much to everyone for all those comments. Let's move on to voting at this time. We'll go to the next slide.

Okay, so for the vote, should the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit 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 open, and please refresh your browser if you don't see the question.

Alli Steiner:

Thanks for your patience. Just give us another moment to make sure we have all the votes.

We are missing Bonnie Zima's vote – if you can try submitting your vote again, Bonnie.

Okay, we've got all the votes. Let's close the vote, please.

Okay, so for the results – 53 percent of the Workgroup members voted, "yes," so that does not meet the threshold for recommendation. The Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit measure is not recommended by the Workgroup for addition to the 2027 Core Sets. Let's go to the next slide, please.

Okay thanks, everyone. I'm going to now going to pass it to Sreyashi Ghosh to present the next measure for addition.

Sreyashi Ghosh:

Thanks, Alli.

The next measure suggested for addition to the 2027 Core Sets is Adults with Diabetes – Oral Evaluation. Next slide, please.

Before we go over the details of this measure, I'd like to highlight that the 2026 Adult Core Set includes the three following measures related to preventive dental care for adults and preventive care for adults with diabetes:

The Oral Evaluation During Pregnancy: Ages 21 to 44 measure assess the percentage of enrolled persons ages 21 to 44 with live birth deliveries in the measurement year who received a comprehensive or periodic oral evaluation during pregnancy.

The Glycemic Status Assessment for Patients with Diabetes measure assesses the percentage of beneficiaries ages 18 to 75 with diabetes type 1 and type 2 whose most recent glycemic status was at the following levels during the measurement year: glycemic status less than 8 percent and glycemic status greater than 9 percent.

The Hemoglobin A1c Control for Patients with Diabetes measure was modified by the measure steward to be renamed as the Glycemic Status Assessment for Patients with Diabetes measure in the 2025 Adult Core Set.

The PQI 01: Diabetes Short-Term Complications Admissions Rate measure assesses the number of hospitalizations for a principal diagnosis of diabetes with short-term complications per 100,000 beneficiary months for beneficiaries aged 18 and older. Next slide, please.

Let's now turn to the measure suggested for addition: Adults with Diabetes – Oral Evaluation. This measure is defined as the percentage of enrolled adults aged 18 years and older with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year. The American Dental Association on behalf of the Dental Quality Alliance, or DQA, is the measure steward; and the measure is a process measure.

The data collection method used for this measure is administrative. The denominator for this measure includes the unduplicated number of enrolled adults aged 18 years and older with diabetes. The numerator for this measure includes the unduplicated number of enrolled adults

with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation.

The measure is currently stratified by age group only and includes 10 age stratifications as listed on this slide. The measure steward also indicated that stratification of this measure by additional factors – such as race, ethnicity, sex, and geography – is feasible, as demonstrated by the DQA oral health dashboard.

This measure was field tested using data from the Iowa and Oregon Medicaid programs. The Oregon Health Authority has included a finalized version of this measure as a metric in its Coordinated Care Organization Quality Incentives Program for several years. Additionally, this measure is included in DQA's online interactive oral health dashboard for reporting dental quality measures using T-MSIS data for all 50 states and the District of Columbia. The dashboard is available on DQA's website, and a link is shown on this slide. Next slide, please.

This measure was discussed at the 2020 Core Sets Annual Review Meeting but was not recommended for addition to the Core Sets. Although the Workgroup noted that the Adults with Diabetes – Oral Evaluation measure would fill a gap in the Adult Core Set and is feasible to report having been implemented in one state's incentive program, some Workgroup members expressed concern that the measure was still undergoing testing and that it might be more related to diabetes, for which there are several other Adult Core Set measures, than oral health care.

The specifications were also not finalized at the time of the 2020 meeting. In their submission, the individual that submitted the measure for addition to the 2027 Core Sets acknowledged the previous Workgroup discussion; and they noted that DQA has since completed testing for the measure in Medicaid programs, and the measure now has finalized specifications. According to the individual who suggested the measure, this measure would fill a gap in the Core Sets as it supports improvement in the integration and coordination of care between medical and dental care systems that are critical to support whole-person health.

This measure focuses on adults with diabetes who are at increased risk for oral disease and consequent impacts on quality of life. They noted that despite recommendations that adults with diabetes be referred to a dentist, almost 60 percent of adults with diabetes have a medical visit but no dental visit. They indicated that these high rates of medical visits, but no dental visits represent an important opportunity to connect adults with diabetes who access the medical system to dental care.

The individual who suggested the measure indicated that measure testing results demonstrate an overall performance gap for Medicaid, with the measure scores ranging from 23 to 34 percent among the testing programs. There were also statistically significant variations in measure performance by age, sex, and geographic location. They argued that Medicaid and CHIP programs and their participating providers can directly influence improvement on this measure and suggested that if added to the Core Sets, the measure could be used to assess Medicaid and CHIP program performance and progress over time. Next slide, please.

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

Alli Steiner:

Great, thank you so much, Sreyashi.

We'll now invite discussion about the Adults with Diabetes – Oral Evaluation measure from Workgroup members. You can raise your hand if you wish to speak; and we will call on you, and you can unmute yourself. Please remember to say your name before making your comment.

It looks like we have a hand from Angela Filzen.

Angela Filzen:

Good afternoon. Again, this is Angela Filzen from Mississippi; and I'm in support of the Workgroup recommending this measure for approval.

I'd say we talked a lot this afternoon about the importance of inter-professional collaborative practice. This particular measure speaks to a bidirectional relationship between diabetes and oral health. When you look at chronic disease and its relation to oral health, we know that many times inflammation is the culprit in an inflammatory response that you can't separate from the head and neck and the rest of the body.

We do also know that oral evaluations are so important as an entry point into the dental care system. They really help us with providing the diagnosis, the risk assessment, the care planning, so that we can facilitate prevention and treatment of periodontal disease or gum disease for which there is no cure, and we have to manage. So, we do know that people who have diabetes have an increased prevalence of gum disease or periodontal disease. This periodontal disease becomes more severe as the persons with diabetes are under poor glycemic control.

So, a measure like this will really help patients to connect the dots of the importance of oral health to their overall health and hopefully see the dental team as a co-manager in the disease. As I think about this for our state, of course Mississippi, we are plagued with high prevalence of diabetes and cardiovascular disease. Unfortunately, in our state we do not have a comprehensive Medicaid benefit for adults which would allow them to be able to get the necessary dental care should they have a chronic disease like diabetes, which having a proper way to chew food and digest food with teeth is important to their overall health and well-being.

So, I really appreciate this. Years ago – maybe ten plus years ago – in a practice setting, we did have a patient. I know this is an isolated event. But as I thought about this measure, I thought to share this story of a patient who presented just to get an exam because she wanted dentures. In this particular exam, the patient was very irate, not able to get her to settle down. As we reviewed her medical history, of course we see diabetes. We did a blood sugar. At that time, I was in a community health center setting and this patient presented with a blood sugar of over 400. Just one instance where poor control, and the patient had not related that to just going to the dentist.

Fortunately for this patient, we were in a facility with a medical provider. We could get the medical team involved; and the patient was cared for, transported to the hospital. But we have this happening a lot. So having a measure as such incorporated would help us to be able to make patients aware of the benefit of oral assessments in helping with disease management and offer a greater, healthier outcome for the patients. Thank you for the opportunity to comment.

Alli Steiner:

Thank you so much, Angela.

Sarah?

Sarah Tomlinson:

Okay, good afternoon. Again, I'm Sarah Tomlinson, a dentist from North Carolina.

As Angela said, periodontal disease is more common in people with diabetes; and it's considered a complication of diabetes. Because regular dental care can help to prevent, delay, or manage periodontal disease, it's an important part of diabetes management. SoSo, although the 2025 Core Sets will include a measure on oral exams for pregnant women, there is value in adding this measure on medical/dental collaboration for patients with diabetes. That includes adults 18 years old and older, both male and female. So, I support adding this measure to the Adult Core Set. Thank you.

Alli Steiner:

Thanks so much, Sarah.

Let's see...Rachel?

Rachel La Croix:

Hi. I just wanted to share that this is a measure that we have included in our new dental plan contract. They just went live February 1st, so we have not yet had the opportunity to collect data on the measure. But this measure does reflect one of the priorities that we had for our new dental plan contract in terms of providing additional services and really trying to improve dental care for special populations in addition to improving children's preventive dental care overall.

So, we did put an emphasis on the contracted dental plans, really making sure that they're trying to connect to care members who are pregnant, members with diabetes, as well as focusing on some other populations, other folks with chronic diseases, and folks that receive services for persons with disability.

So, this measure – I know that there aren't measures out there for all of these special populations. But this measure really fit one of the areas we were looking for through our contracts. So, I would support the addition of this measure.

Alli Steiner:

Thank you so much, Rachel.

Any other comments from Workgroup members? David Kelley.

David Kelley:

Good afternoon. I'm supportive of this measure. I know that we've done a lot of work with our MCOs, especially with diabetics; and some of our dental schools in Pennsylvania have done some work around training their dentists, their dental students around the high blood pressure and diabetes management and working with the medical community in their medical/dental homes -- so highly supportive.

I guess one question that I have, and we do have – we used to have a full dental benefit. We skinned it back a decade ago, but we would still pay for basic dental evaluation services for

adults. I was just curious if there's – if Kaiser or others have an understanding of how many state Medicaid programs do adult dental – either have a limited benefit or no benefit?

Alli Steiner:

Thanks, David, that's a great question. We were also looking for that information right before the meeting. So, we do have access to – there's a resource that NASHP put out, but just to acknowledge that that resource is a little bit out of date at this time. It says that 8 states provide emergency coverage; 25 states and D.C. provide extensive coverage; and 14 states provide limited coverage; and 3 states provide no coverage. But like I said, this resource is from 2022. So, I would be curious if anybody on the phone has any updated information from those statistics.

David Kelley:

I think just based on – so you said that three states have no dental benefit. So that's three states that wouldn't be able to report. So, I'm less concerned, unless that's moved dramatically the wrong direction. So, I think even that information is helpful. Again, I'm actually very supportive of this measure.

Alli Steiner:

Thank you so much.

Any other Workgroup member comments? I think I saw Rich's hand earlier. Did you want to make a comment, Rich?

Richard Antonelli:

Well, for me, it's always the highest praise if Dave Kelley asks a question that I was thinking about.

Alli Steiner:

Oh, good.

Richard Antonelli:

As is, I don't know how heavy of a lift it would be in certain states about that. So just so that I can reflect back though, are you saying that we should vote on the measure not knowing the correct answer for the number of states that have adult dental benefits in the Medicaid programs? Is that the guidance?

Alli Steiner:

I'm sorry. Is that a question for—?

Richard Antonelli:

Yeah, that's actually a question for the MPR staff. It sounds like Dave was okay knowing that as of 2022, only three states didn't have a benefit. I guess Rich is struggling with having three-ish years' old data and not having it now. So, are you expecting us to vote on the measure with possibly outdated information?

Alli Steiner:

Yes, I think we would encourage you to vote on the measure knowing that states' dental benefits can change; and we will – yes, I think that we'll have to vote with the current information that we have available.

Richard Antonelli:

Okay, thank you.

Alli Steiner:

Thanks, Rich.

I see – actually, I see a hand from DQA, and I don't know if you have a response – a more updated response to that statistic. Can we unmute Hana?

Hana Alberti:

I'm not sure if you can hear me.

Alli Steiner:

Yes, we can.

Hana Alberti:

Okay, so we do have updated data that over 40 states do offer this as an adult benefit.

Alli Steiner:

Wonderful, thank you so much for jumping in with that. I just also wanted to add that because this would be added to the Adult Core Set, it would be a voluntary measure for Adult Core Set reporting.

Laura Boutwell? Can we move Laura up to a panelist, please? Thank you.

Laura Boutwell:

Hello, this is Laura. Can you hear me?

Alli Steiner:

Yes, we can.

Laura Boutwell:

Hi, yes, thank you. I'm Laura. I'm from Virginia Medicaid. Thank you so much. I did just want to voice my support for this measure as well. Virginia has expanded dental for our adults in recent years, and we have definitely seen a critical need for our adult populations, especially those with chronic conditions, to get access to this care. We monitor a variety of measures for our adult population with this access to dental, and we're definitely seeing the need in our state – so wanted to voice my support, thank you.

Alli Steiner:

Thank you, Laura.

Stacey?

Stacey Bartell:

Yes, thank you. Stacy Bartell.

I just had a question of the Dental Quality Alliance also about the upper age limit of this measure. A majority of the measures that provide medication end at 75 with the thought process that the majority of them are about prevention long term down the road; and different priorities come to place when you have a 75- or 80-year-old patient in front of you when we're at visits, and different conversations are had. So, I was just curious about the upper end, and was that an appropriate endpoint for this measure. At what age do you stop this recommendation that they need to go the dentist every year, for diabetics particularly with dental disease. I'm not sure it makes a difference in the outcome at that point.

Alli Steiner:

Yeah, thanks, Stacey.

Can we please unmute Hana, please, Derek?

Hana Alberti:

Thank you for allowing me. Again, my name is Dr. Hana Alberti from the American Dental Association on behalf of the DQA. Patients are recommended to visit their dentist, even if they are edentulous, through their lifespan.

Stacey Bartell:

How does that change though differently in diabetic patients if we need to measure that, just out of curiosity?

Hana Alberti:

I guess -- I'm so sorry. I'm not understanding the question.

Stacey Bartell:

So, we -- I guess the majority of diabetic measures end at 75. So, we're asking this diabetic measure to extend beyond 75. I'm just curious why this measure – why we have to measure this differently in the diabetic population for this age group.

Hana Alberti:

Well, I believe the intent here is that we're hoping that patients retain their teeth even after the age of 75. But as for -- Jill, technically, if there was a specific reason why we didn't stop at age 75?

Alli Steiner:

Is Jill on the line? If so, can you raise your hand, and we can unmute you. Please unmute Jill, Derek. Thank you.

Jill Herndon:

Hi, I'm not sure if I'm distinguishing between a clinical question or a – I'm not sure if the question is clinical, or if it's a burden feasibility question in terms of aligning measures. I can speak more to the feasibility aspects and say that I think it's definitely possible to go back and to look at the reporting age ranges for the purposes of alignment across Core Set measures.

If it's a question in terms of appropriate clinical care, I would need to have my clinical colleagues address that component of it -- so maybe some clarification on the question.

Alli Steiner:

Thanks, Hana; and thanks, Jill, for jumping in. Is anyone on the phone able to respond to the clinical question that's being raised?

David?

David Kelley:

So being a geriatrician, oral health is extremely important in all bands, including the upper age bands that are listed in this measure. When you look at especially individuals as they do start to lose their teeth, if you can salvage as many as possible for as long as possible that certainly helps with individuals in their nutritional status. There are some studies also looking at individuals living with dementia and how their oral status is really important in being able to maintain their nutrition and some of their functionality.

So, I would see great value in continuing up to these upper age bands. As you start to lose teeth, you may also then need to think in terms of providing dentures so that individuals can continue to have good oral intake and that their nutritional status continues to be improved. Again, you're not just looking at teeth. You're looking at the gums. You're looking at the oral cavity. Dentists do this much better than internists do and can look for other types of pathology.

So, I would also just say that as a practical point, in most Medicaid programs that are not including LTSS or dual-eligibles population in those upper age bands goes down; and those numerators and demonstrations are going to be pretty small. Hopefully that's helpful.

Stacey Bartell:

Yeah, I think I'm just more reflecting on the fact that when we hear from physicians and we hear about the number of quality measures and things they have to report on and things they're responsible for, one of the things we just want to be very mindful of is we're not saying that as you get older, evaluating your teeth isn't important.

I guess I'm just trying to point out here that we're kind of saying we're putting this measure into place that evaluating your teeth when you get older is more important if you have diabetes because this measure isn't for just older patients, right? This measure is for older diabetic patients, where we're saying they need those dental appointments for some reason, that they would need to have a quality tool or quality measurement. I just don't know that that value

makes a difference from – I get it, it's important. But if it's important for all patients, then that measure should be for all patients as they age, not just diabetic patients as they age.

That's all I'm trying to point out is that we're kind of making a difference here in diabetic patients suggesting that it's more important in those patients as they age that we measure it than in other patients.

Alli Steiner:

Thanks, Stacey.

Does any other Workgroup member have a comment that they would like to make?

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

So now we'd like to provide an opportunity for public comment. If you would like to make a comment about the Adults with Diabetes – Oral Evaluation measure, please use the "raise hand" feature in the bottom right of the participant panel to join the queue; and lower your hand when you're done. We will call on you and let you know when you've been unmuted. Just a friendly reminder to try to keep your comments brief if possible. We want to make sure we have the chance to hear from everyone interested in making a public comment.

So, we will start with Chris.

Derek, can you please unmute Chris?

Chris Farrell:

Good afternoon again. My name is Chris Farrell, and I'm representing the American Dental Hygienists Association. But I'm also the Oral Health Program Director for the Oral Health program at the Michigan Department of Health and Human Services.

So, these are my comments for ADHA – that they support the inclusion of Adults with Diabetes – Oral Evaluation into the Adult Core Set. Dental hygiene care is associated with successful long-term management of chronic diseases such as diabetes. Diabetes and oral health are among two of the leading health indicators in the U.S. Diabetes can cause changes in the teeth and gums, especially when poorly controlled. Conversely, having poor oral health can lead to further complications of diabetes.

Dental hygienists are prevention specialists invested in ongoing care of the patient and the total health of the patient. This measure can allow for collaboration of primary care provider and dental professionals on the management of care, and it encompasses a wider definition of care for patients. So ADHA would recommend support for this measure.

Again, on behalf of the – from my position as the Oral Health Program Director, I want you also to be aware that there were 15 states that received CDC cooperative agreements titled, "State Promotion of Strategies to Advance Oral Health." One activity is the data analysis to support medical/dental integration, and that one activity is specific to diabetes. So, the description requires these 15 states to analyze, interpret, and disseminate secondary data about relationship between the oral health in adults with diabetes and their overall health, as well as their use and access to medical and dental care.

So, I think this Core Set aligns very closely with what the CDC is asking for the states to measure in terms of medical/dental integration around diabetes and oral health. Thank you.

Alli Steiner:

Thank you so much, Chris.

Shillpa?

Shillpa Naavaal:

Hi, everyone. Shillpa Naavaal. I'm representing the American Association of Public Health Dentistry. I would strongly voice support for this measure. Again, knowing the bidirectional relationship between diabetes and oral health and kind of both being chronic conditions, pretty common one, I think the burden is really high. By providing and supporting this measure, it actually could allow to improve the overall health and connect the person which otherwise would not be connected.

We know from the research that many people who have diabetes have medical referral but not the dental referral. So, I think it's a lost opportunity if we are not measuring it. And by measuring it, it will allow to kind of identify those people and connect them to care to make sure their overall health is improved, diabetes is better controlled, as well as they're connected with oral care. Thank you.

Alli Steiner:

Thank you so much for your comments.

We'll go to Marie next.

Marie Schweinebraten:

Thank you. My name is Marie Schweinebraten. I'm a periodontist, and I've practiced for over 40 years. I am also representing the American Academy of Periodontology and am also on the Dental Quality Alliance – so to give you a little bit of background information.

I'll keep this brief because I support everything that's been said about this particular measure. The systemic link between periodontal disease and diabetes is a very strong one. It was probably one of the very first one that was ever reported through research and literature, and it's a connection that's kind of a two-way street. Not only does a diabetic need to be checked for oral complications because periodontitis has a much higher risk factor when the patient is a diabetic, but also when that periodontitis is controlled, it can help control their diabetes.

So, this measurement to determine if a diabetic patient has had an oral evaluation in the past year is an opportunity to greatly improve oral health of these patients through early diagnosis and treatment of dental and especially periodontal disease. But it's also besides those two improvements in oral health and general health, I think it's a great opportunity to educate patients and let them know what a correct diet can be and how one thing can affect the other.

So, I would encourage you to include this in your Core Set for adults. Thank you for letting me speak my piece.

Alli Steiner:

Thank you so much, Marie.

We'll go to Julie next.

Julie Reynolds:

Hi, thank you. Julie Reynolds again, faculty and public health dentist from the University of Iowa. I'm disclosing that I'm current Chair of the Dental Quality Alliance. I'm speaking in support of this measure because it would provide the important opportunity to improve dental care use for this group of adults who are at especially high risk for oral disease for the reasons that we've already heard. As was mentioned earlier, in measure testing the DQA found that among adults with Medicaid who had diabetes over two-thirds did not have a recent dental checkup. This provides an important improvement opportunity for state Medicaid programs to encourage referral tracking and follow-up and outreach to improve dental care use for this high-risk population. This type of information can be actionable for state Medicaid programs or managed care plans by identifying members with diabetes who haven't had a dental checkup and to do targeted outreach to help this population get into care.

Thank you so much for the opportunity to comment, and please consider supporting this measure.

Alli Steiner:

Thank you so much, Julie.

Okay, well I'm not seeing any hands raised. Let's move on to the vote.

Just a general reminder for folks that were not on the meeting yesterday. The threshold for recommendation is 67 percent or two-thirds. I just wanted to remind folks of that threshold.

For the next vote, should the Adults with Diabetes – Oral Evaluation 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.

Okay, let's close the vote, please.

Okay, so now for the results, 72 percent of the Workgroup members voted "yes." That does meet the threshold for recommendation. The Adults with Diabetes – Oral Evaluation measure is recommended by the Workgroup for the addition to the 2027 Core Sets.

We were able to make up a little bit of time, so we wanted to just pause before we move on. Because the last vote on the Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit was such a close vote, we wanted to just take a moment to debrief on that a little bit and hear if any Workgroup members are interested in sharing why they did not vote for that measure. So please feel free to raise your hand if you wanted to provide any insight on your vote there. Thank you so much.

Kim Elliott?

Kim Elliott:

The only reason I voted no on it was a little bit of a concern on coverage across states and the ability for all states to be able to report it should it ever become a mandatory measure. So that was my primary reason.

Alli Steiner:

Thank you so much, Kim, for sharing that.

Let's hear from Jeff Huebner next, please. Derek, can you unmute Jeff?

Jeff Huebner:

Can you hear me?

Alli Steiner:

Yes, we can. Thanks for asking.

Jeff Huebner:

Okay, I actually voted yes, so sorry to respond. I have to say I was very torn on this one. I thought all of the discussion and everything that was shared was extremely helpful, and really appreciate that there was support for improving oral health and the importance of doing that across the whole Workgroup panel and the people who've been working hard on that measure and programs to support that sort of improvement and collaboration.

I think those of us probably on the medical side – and you heard this a little bit in the conversation – there's an overwhelming sense, I think, from the medical profession around overmeasurement and burnout. Because the measure focuses potentially or could be used to focus in a way that penalizes clinical providers on the front lines, that part of it makes it challenging probably.

So, I think the intention is really good. I'm not convinced of the denominator and numerator and the six months' timeline. But I know a lot of work has gone into that, and I was really heartened to hear about all the efforts that have happened around the country to improve care coordination and collaboration. I think, as we've talked about with lots of the other measures up for discussion this time and in my previous year, a lot of this comes down to how these measures are used and whether they're going to be used at the level of policy improvement, population health and public health improvement, or used as a way to potentially penalize clinicians on the front lines or add to burnout.

So, I think those are some of the things we're all thinking about.

Alli Steiner:

Thank you so much, Jeff. Did any other Workgroup members want to provide insight on their vote for that childhood measure?

Jakenna?

Jakenna Lebsock:

Can you hear me?

Alli Steiner:

Yes, we can.

Jakenna Lebsock:

Okay, Jakenna Lebsock, Arizona. I voted no honestly because we have a very small population in Arizona -- our adult population that has dental benefits. So, for our state, it doesn't make a lot of sense, especially if it were to ever become a mandatory measure. We just don't have a comprehensive benefit and so would really struggle in producing this measure.

Alli Steiner:

Thanks, Jakenna.

Okay, I'm not seeing any other hands. So why don't we move on. We're going to move to a break. We're going to have a 15-minute break here, and we will be back at 2:55 Eastern. Thanks, everybody.

BREAK

Patricia Rowan:

All right, hi, everyone. Welcome back from the break. We are nearing the end of our time together, and we are now going to turn our discussion, to our discussion of the gap areas in Adult and Child Core Sets. This discussion will inform the public Call for Measures for the 2028 Child and Adult Core Sets. Let's go to the next slide.

So, each year, the Workgroup discusses measure gaps in the Child and Adult Core Sets to inform the Call for Measures for the subsequent annual review. Today, Mathematica will provide a high-level overview of gap areas identified by the Workgroup during last year's Core Sets Review cycle. Then the Workgroup will discuss gap appears for the 2028 public Call for Measures. We will provide an opportunity for public comment at the end of the discussion. Next slide.

We've organized the gap areas identified by the 2026 Core Sets Review Workgroup into five categories:

The first category is Maternal and Perinatal Health. I won't read the entire list on the slide, but the gaps identified in this category include maternal morbidity and mortality and maternal substance use disorder.

The second category is Patient-Reported Outcomes and Experience of Care. Here, some of the gaps identified were patient-reported outcomes, patient engagement, and person-centered primary care measures, as well as consumer experience related to respectful care beyond what is included in the CAHPS Health Plan Survey. Next slide.

The third category is Behavioral Health Care. Previously identified gaps in this area include outcome measures, particularly depression treatment outcomes, and screening and referral to treatment for anxiety disorders. Next slide.

Next, we have the Stratification and Social Drivers of Health category. Previously mentioned gaps in this area include measurement of screening for social needs or intervention and assessment of social drivers of health across the lifespan.

Last but not least, we list a few other gaps mentioned by the 2026 Workgroup which include adult immunization and screening and treatment for hepatitis C. Next slide.

As I mentioned yesterday, we are going to take a round-robin approach; and we'll ask each Workgroup member to mention one gap area that they think should be a priority to address through next year's public Call for Measures. Workgroup members may also add support to a gap area mentioned by another Workgroup member. We're going to go in order of the roster used for the rollcall, so we'll start by hearing from our two co-chairs. I'll start with Kim first.

Kim, you should be able to unmute yourself. Yes, go ahead.

Kim Elliott:

Thank you, yes. This might actually be two, but I'm going to make it one. I think that there's a gap when looking at care coordination, particularly as it pertains to the social determinants of health connecting with community resources to address some of those health needs and coordination in getting individuals in for care. That, I think, is one of the gap areas. There aren't a lot of measures out there that really approach that from that perspective. So, I think that's something that we could focus on.

Patricia Rowan:

Thank you, Kim.

Rachel?

Rachel La Croix:

At risk of going ahead and piggybacking on someone else's, Kim and I were thinking along the same lines. I also was thinking of social drivers of health and particularly providing services and supports for members through their communities to be able to address some of those areas where just having more resources – whether it's helping someone get a GED, helping someone better access housing, or different things like that – really looking at what supports can we put in place for those things on how those could ultimately complement and contribute to better health for members.

Patricia Rowan:

Thanks, Rachel.

Now we'll hear from the rest of the Workgroup in the order shown in the roster. So, I'll start next with Ben Anderson. Ben, you should be able to unmute yourself.

Benjamin Anderson:

Hi, yes, thank you.

I know we're supposed to pick one, but I think what's happening – or the need around having a social drivers measure certainly warrants a plus one. Then just also want to continue to plug the

need for more consumer experience measures, particularly those that get at how well a patient feels respected during their encounters and what the patient perspective is on how providers are centering their interests and valuing their interests during the experience. That's it. Thank you.

Patricia Rowan:

Thank you, Ben.

Rich Antonelli?

Richard Antonelli:

Thank you. You hear me?

Patricia Rowan:

Yes, we can.

Richard Antonelli:

Hello?

Patricia Rowan:

We can hear you, Rich, go ahead.

Richard Antonelli:

So, I would -- basically I'd say what I said last year because I'm still keen on it, which is even existing measures could be stratified to reflect certain types of disabilities. To even have a little bit of a celebration of sorts, the oral evaluation for adults with diabetes measure that we recommended for consideration for inclusion, that's great. That's a type of a disability.

I particularly would like to harmonize with the EPSDT State Health Official letter from September 26, 2024. Lots of opportunity in there to do the plus one with the social determinants. But in particular to think about how children, youth, and if we could extend it to at adults but at least children and youth with disabilities are faring in the system of system of existing measures. Thank you.

Patricia Rowan:

Thank you, Rich.

Stacey Bartell?

Stacey Bartell:

All right, so do we have a suicide screening one? I was briefly looking through the measures. I don't think we do. We have a suicide risk assessment in adolescents. But it looks like that one went away. So, I'm going to—

Patricia Rowan:

We have a depression screening measure, but that's it. Thank you.

Stacey Bartell:

So, I'm going to go back to the suicide screening measure. Piggyback that onto, like back to social drivers, the loneliness question or isolation question. I think that's a big one for a lot. Some social driver screens have that question on there; some do not.

Then I'm going back to maternal morbidity and mortality – anything we can do to reduce risk. I think there's some new cardiovascular measures for pregnancy that we should think about.

Patricia Rowan:

Thank you, Stacey.

Laura Boutwell?

Laura Boutwell:

Hi, thank you. I'm going to actually really plus one Stacey because my number one – and this is a high-priority area for Virginia – is maternal morbidity and mortality. That is an area that we would really like to see some additional work. Yes, so that would be my recommendation.

Patricia Rowan:

Thank you, Laura.

Matt Brannon? Matt, sorry, we missed the first half of what you said. Do you mind starting over?

Matt Brannon:

No, that's okay. I've got an echo here, so hold on one second.

I'm here in West Virginia, sorry. That's all.

Patricia Rowan:

We did not hear what you said, Matt. I'm sorry. I don't know if -- I think the echo -- you might be connected through your computer and on your phone. Can you just repeat?

Matt Brannon:

Let's try that again. Still echoing.

Patricia Rowan:

Okay, we'll come back to you, Matt, thank you.

Let's go to Joanne Bush.

Joanne Bush:

Hello, can you hear me?

Patricia Rowan:

Yes, we can.

Joanne Bush:

I apologize for my voice. I'm fighting a cold.

So here in Iowa we see a gap in the coordination and social determinants of health, specifically in the area, like others mentioned, in loneliness and for suicide.

Patricia Rowan:

Thank you, Joanne.

Stacey Carpenter?

Stacey Carpenter:

I do want to just echo the maternal morbidity and mortality as one. But I also think we focus a lot on depression screenings, which is very important. But I feel like there's a lack of training and treatment referral for children, maternal health, and for adults.

Patricia Rowan:

Thank you, Stacey.

Roshanda?

Roshanda Clemons:

Hi, so I'd like to vote for a plus one for maternal morbidity and mortality rates with special focus on closing the gap in disparities. I know that just given the fact that we pay the highest per capita for medical care. But for industrialized counties, we're like number one. I think the current CDC numbers are starting to show a different trend. We're starting to do a little better. However, the gaps are still too wide, where you're looking at certain populations that have anywhere from three to five times the rate for mortality rates. And in even populations that are often suppressed because their numbers are often very low, they're at 10 to 11 times the rate.

So, my vote is to continue to find more measures that are focused on maternal morbidity and mortality rates. Thank you.

Patricia Rowan:

Thank you.

Lindsay Cogan?

Lindsay Cogan:

Yes, hi. I think I just would plus one the social determinants of health. I think I had asked for this in the gap area over the last several years. We do think it's an important area and one in which we have a lot of focus on right now, particularly in New York State.

The maternal morbidity and mortality is also an area where I think it would be good to see some additional work. We know that AHRQ is beta testing some additional measures that we are

spending some time looking into. So, it might be good if states are implementing or putting together some more of these population-based measures. That's helpful. It's often difficult to take facility-based measures and bring them up to a state level. It tends to get just a little bit tricky. So, we've been leaning a little bit more into more population-based measurement to try to get an idea of more on maternal health indicators.

I think that's all I have.

Patricia Rowan:

Thanks, Lindsay.

Erica David-Park?

Erica David-Park:

Hello, I would actually like to piggyback partially on Rich Antonelli's callout regarding measures that have an impact on individuals with disabilities. We know to focus on children, but I also would like to add on there if maybe some work on some measures that are looking at physical disabilities in adults also, really in some of the more clinical concerns that can impact that population – like falls and UTIs, wounds, et cetera.

Patricia Rowan:

Thank you, Erica.

Anne Edwards?

Anne Edwards:

Thank you and thanks to Stacey who first brought up suicide. But maybe to lean into a little bit of a variation on Rich's comments on stratification, particularly focusing on immunizations. That's something that's on the Core Sets that of course is very core to pediatrics. But I think there might be some opportunity for further development and refinement really to look at what might be systems issues, community access issues, and then recognizing that seeing hesitancy in more individual-level decision-making. So, want to highlight some opportunities there to do some further refinement of those measures. Thanks.

Patricia Rowan:

Thank you.

Next, we have Clara. Is Clara on the line? We might not have Clara. That's okay.

Angela?

Angela Filzen:

Hi, yes, two things that I've mentioned I'd like to piggyback on – the shared information around social drivers of health and its relation and assessment of community resources. I think that's going to be very important to achieving healthier outcomes across the lifespan. I think there's still more work to do with the oral health integration efforts that we've started as it relates to that utilization part. So, look to see more around that in the future. Thank you.

Patricia Rowan:

Thank you, Angela.

Sara Hackbart?

Sara Hackbart:

Hi, yes, thank you.

Patricia Rowan:

Oh, Sara, can you unmute yourself again? Sorry, go ahead.

Sara Hackbart:

There it went. Can you hear me?

Patricia Rowan:

Yeah, we can hear you now.

Sara Hackbart:

Okay, thank you. So just a little bit of background about me. I'm a licensed marriage and family therapist, and I have a background in case management working with youth with serious emotional disturbance and then also measuring quality in long-term services and support. I would just kind of piggyback a little bit on what Rich and Erica had shared around stratification and individuals with disabilities; and specifically, children and youth with special health care needs or disabilities.

I am looking forward to looking at the HCBS measure set as it starts to be implemented and looking at the rates and what we're finding there. However, that HCBS measure set does not address individuals under the age of 18. I do think that this is an opportunity for us to really look at this population and be able to further understand and measure whether their experience of care or outcomes and specifically as well related to intellectual and developmental disabilities for that population that is under the age of 18 to be able to provide some clarity and understanding and measurement for that population as well. Thank you.

Patricia Rowan:

Thank you, Sara.

We got a message from Matt Brannon that he is still having audio issues, but that he would plus one with social determinants of health topic and anything related to care coordination efforts.

Thank you, Matt, for that.

Richard Holaday?

Richard Holaday:

Can you hear me?

Patricia Rowan:

Yes, we can, go ahead.

Richard Holaday:

All right, thank you. So, a couple plus ones, the screening for social needs and especially housing continues to be an issue in Delaware. Care coordination, I would like to plus one that but also perhaps maternal care coordination. Then also plus one to maternal morbidity and mortality. Thank you.

Patricia Rowan:

Thank you, Richard.

Jeff Huebner? Go ahead, Jeff.

Jeff Huebner:

Yeah, I would suggest a plus one on anxiety, especially in children. I think people know it can be very debilitating, and I don't think there's any measures that are out there for this right now in the Core Sets. Then definitely a plus one on health-related social needs focused on access – moving members with positive screenings to accessing services. I know there was a robust discussion last year and a pretty close vote, as I recall. I was surprised it didn't come back this year.

Patricia Rowan:

Thank you, Jeff.

David Kelley?

David Kelley:

I would – I'll plus one the health-related social needs and I think NCQA's measure, the social needs screening and referral. There's probably still some room or opportunity for improvement in data gathering there, but I think there's a lot of work that's been – a lot of progress that's been made in standardizing things using Z codes and working with the Gravity Project to standardize things. So maybe it will come back next year.

Plus, one on the maternal morbidity. And then I would advocate, just as we did a hepatitis cascade of care, to think in terms of an HIV cascade of care. On the HIV measure, it's the holy grail looking for individuals that have the virus suppressed based on viral load. That's great; that's hard to get, and I forget how many states – it's still a minority of states that report that. But there could likewise be a cascade of HIV care looking at who has HIV, did they get a visit in a given year – which is part of the current measure. And then did they even get the screening test? We do this in Pennsylvania, and then we also look at medication possession ratio. We still haven't gotten to the holy grail yet; but again, there could be that cascade of HIV care that goes beyond the current measure that's on the Core Sets.

Being a geriatrician, I'll shift to pediatrics. I still think that there's a great opportunity to develop measures around adverse childhood events by identifying those individuals. The harder part is identifying, are they getting appropriate treatment. But I think looking at – even starting out with

some process measures to identify those individuals and the extent of their adverse childhood events I think would be really important. I think there are opportunities to use claims, including Z codes and other things coming in from the health-related social needs screening that gets done at the provider level.

Likewise, I'd like to see a cascade of care for developmental delay. We do a screening, but what happens to those that screen positive? What type of services do they get? So again, I'm just saying let's take current topics and let's make them better. Let's look at – move away from just processes and try to get to outcomes. Those are my thoughts, thanks.

Patricia Rowan:

Thank you, David.

David Kroll?

David Kroll:

Well, I completely agree with everything that's been said. The one thing I will add here is that in the behavioral health space, we've been having more and more conversations about how quality measures of the future should move beyond just measuring symptoms and kind of traditional health metrics but also looking at a diagnostically cross-cutting issues functioning in general wellness.

So, I think that – I suspect that probably similar conversations have occurred with respect to other specialties as well, but I think that's something that might be worth thinking about for the benefit of the Core Sets as well. Thanks.

Patricia Rowan:

Thank you.

Jakenna? We might have lost Jakenna.

I'm going to actually pause and skip ahead to Bonnie Silva, who has let us know that she needs to drop off in a few minutes.

Bonnie, would you like to go?

Bonnie Silva:

Sure. Thank you so much. I really want to plus one Richard Antonelli's request for stratification of our current measures to better identify people with disabilities. I think a core component of Medicaid programs is to serve people with disabilities. While we have the HCBS quality measures, what we don't have is really good insight around how those people are being served across services. I think that is just such an excellent suggestion.

Patricia Rowan:

Thank you, Bonnie.

I'm going to go back to Jakenna.

Jakenna, can you raise your hand again? We might need to do it that way. Okay, Jakenna, you should be able to unmute yourself now. Go ahead.

Jakenna Lebsock:

Can you hear me now?

Patricia Rowan:

Yes, we can hear you now.

Jakenna Lebsock:

I would like to plus one the health-related social needs, social determinants of health. I think there's a lot of opportunity there. Also, the maternal morbidity/mortality – plus one there. And then would also plus one the enhanced stratification cross-measures of looking at individuals with disabilities. I think that would be a really big benefit to the states to have some of that documented also.

Patricia Rowan:

Great, thank you.

Hannah Lee-Brown?

Hannah Lee-Brown:

Yes, thanks. Jakenna and Bonnie just said it so eloquently. I'd really like to plus one on the idea of stratification across measures focusing on those individuals with disability and understanding how they're served across the program.

But then I'd also like to lend support as well to an SDOH measure, something around social needs screening, referrals, and care coordination.

Patricia Rowan:

Thank you.

Katherine Leyba? Go ahead, Katherine. You should be able to unmute yourself.

Katherine Leyba:

Okay, can you hear me now?

Patricia Rowan:

Yes, we can.

Katherine Leyba:

Okay, great, thank you.

Okay, so I'd really like to plus one on the maternal mortality and morbidity. I really like the suggestion of additional measurement indicators. This is one of our target groups in our state –

our population groups – and it really would be helpful to stratify by these indicators or additional indicators that would allow us to develop more focused interventions for our programs.

I'd also like to plus one the social drivers of health. I do really like the idea of being able to track referrals and involve care coordination into those referral tracking. And definitely plus one on enhanced stratification to identify individuals with disabilities. That's it, thanks.

Patricia Rowan:

Thank you.

Chimene? You should be able to unmute yourself.

Chimene Liburd:

Sorry, I couldn't get to the mute button fast enough, my apologies.

Patricia Rowan:

No problem.

Chimene Liburd:

I want to plus one maternal health as well as suicide. One of the things that I, as a Board-certified internal medicine physician and lifestyle medicine physician, one of the things that I think is important to address is the behavior modifications that can actually make an impact on changes to some of the chronic conditions, like diabetes and high blood pressure, with the focus on value-based care as well as looking at HEDIS and some of the measures.

Providers sometimes get dinged for taking patients off of medications. So, figuring out a way to create a measure set that addresses some of the lifestyle modifications that are important and valuable in managing chronic conditions and also to reward those providers who actually spend the time, as we look for these value-based payment arrangements. But to reward those providers who spend the time and energy in counseling patients on diet, exercise, cognitive behavior, and/or also supporting lifestyle medicine physicians who actually do that work.

I think we have – there's a measure on nutrition and counseling for children. I think there should probably be something along the lines as well for adults. Thank you.

Patricia Rowan:

Thank you.

Angela Parker?

Angela Parker:

Yes, thank you.

I would have to do a plus one as well on the maternal mortality and morbidity. I am on a workgroup regarding that and how we can potentially improve in that area. Also, the social determinants of health. I will echo David in the challenge providers have had in getting them to utilize Z codes and/or the LOINC codes. Hopefully by then, maybe that will be utilized a little bit more.

I'd also like to add low-dose CT lung cancer screening as something to be looking at as well. This is a big issue in the state of Kentucky. I am on an advisory committee, and I know they are very interested in adding this as a HEDIS measure as well. So, I'd like to add that on too.

Patricia Rowan:

Thank you, Angela.

Lisa Patton?

Lisa Patton:

Yeah, thank you. I'd like to plus up the screening for health-related social needs. I know we've had lots of discussion around that and a big push on that. So, I think I'd love to revisit that again. Like I think, Jeff mentioned, I was surprised we didn't have that one back; but I guess I could have helped out with that, couldn't I?

Also, in terms of the stratification of existing measures, I think that's an important place for us all to be working, building out we already have in the core, and where we can find some of that data that we're very interested in.

Then lastly, I really appreciated David's comments on the adverse childhood experiences. I think having a measure in that area would provide us with a lot of information in a lot of areas that we could take more action for those people that are most affected by those childhood challenges.

Yeah, I think all three of those would be among my top few.

Patricia Rowan:

Thank you, Lisa.

Laura Pennington?

Laura Pennington:

Thanks, so a couple plus ones. Definitely interested in seeing screening for anxiety incorporated into some of the mental health measures, especially for the child and adolescent populations. Also, maternal care coordination, that's something we're very interested in, in Washington State.

I'll add one gap area that I haven't heard yet. I don't know about other states, but in Washington State syphilis is becoming a real problem, especially in our older adult population. So, we have yet to see a measure for screening for syphilis and have kind of been using other measures, like chlamydia screening, as proxies. But we would love to see a measure around screening for syphilis.

Also, plus one David Kelley's suggestion about a more robust HIV measure, similar to the hep C ones he proposed.

Patricia Rowan:

Thank you, Laura.

Grant Rich?

Grant Rich:

Hello, can you hear me? Hello?

Patricia Rowan:

Yes, Grant, we can hear you.

Grant Rich:

All right, yeah, I'm a psychologist. When I was at University of Chicago in the 1990s, we were taught anxiety disorders had about a lifetime prevalence of 8 percent. Now it's over one in three. So, I definitely, as I did last year, support adding some kind of screening/referral measure for anxiety disorders, perhaps using the Spielberger State-Trait Anxiety Inventory that distinguishes between the immediate state and the enduring personality characteristic. Of course, these are at elevated rates in persons with chronic or terminal illnesses, and you see all the usual physical manifestations itself – the muscle tension, sometimes camptocormia. These diagnoses some of you may know distinguish from the PTSD, which under the DSM-5-TR, text revision, is its own distinct category which represents a 6 percent lifetime prevalence rate.

Someone mentioned its relevance to youth. You may be familiar with the million-copy selling Anxiety Generation about the pandemic, if you will, of youth anxiety. So, I really think we should attend to it. As you know, sometimes anxiety disorders are reduced as not being as significant of some others. But it presents an elevated risk for such risky behaviors as self-medication and coping through alcohol and other means.

So, I'd suggest anxiety disorders, and I'd also plus one the ACEs, the adverse childhood experiences, and add to that if we're going to look at ACEs maybe also look at PCEs, the positive childhood experiences that can mitigate and buffer ACEs.

I'll also plus one the social determinants from Kim and Rachel. That's all.

Patricia Rowan:

Thank you.

Next, we would have Kai.

Kai Tao:

So, hearing people talk about maternal mortality and morbidity, having been a midwife for over two decades primarily with only Medicaid patients, we know there's a lot of discussion around implicit and possibly explicit – none of us here, of course – bias that's happening affecting these outcomes. Yes, some definitely medical ones, but a lot of it is how people are treated.

I do think it's important – we talked about this yesterday when we talked about the contraceptive care for women, the CCW one, as well as the postpartum one, contraceptive care postpartum, talking about the concerns around coercion. I would really like us to consider using a balancing measure for that, which currently – and I think one of you spoke to it, our Washington friends – the PCCC, the Patient-Centered Contraceptive Counseling. It's a very simple patient-reported outcome measure with only four questions – very different than what I've seen from a lot of these CAHPS surveys, Press Ganey, hospital surveys that kind of go on and on. It's four simple questions on the Likert scale from poor to excellent, and the four questions are:

- Respected me as a person,
- Let me say what matters to me about my birth control method,
- Taking my preferences about my birth control seriously,
- Give me enough information to make the best decision about my birth control method.

Again, from poor to excellent, and how it's used is we'll want to see a percentage or that score of excellent across the board.

With that said, I do think this translates because we've been using this in Illinois. It translates to providers who are taking care of obstetric patients as well. It's often the same providers. I'm not saying it's the providers' fault necessarily. It's a systems issue. But being cognizant of this and really trying to measure how the patient is doing. We even have providers who think they're doing a great job, but they may not be; and that's more of the implicit part of course.

But I do think it's great to have this balancing measure, and it also transcends into how we overall care for people of obstetric and reproductive age, which can also hopefully influence the very much preventable deaths and can decrease the disparities we're seeing in obstetrics. So that's my desire.

Patricia Rowan:

Thank you.

Kai Tao:

And it is NQF-endorsed as of 2020. Because we can all say, oh, there's different surveys. But they went through the validation, NQF endorsed by 2020. And now under the new one, the Partnership for Quality Measurement, is still being recognized as a validated tool. Thanks.

Patricia Rowan:

Thank you.

Sarah Tomlinson?

Sarah Tomlinson:

I'd like to fill a gap in the patient-reported outcome measures, and if we could include an oral health one so much the better. But I love the idea I think about doing that for the disabled population to get their feedback.

Also, North Carolina is focusing on maternal health; so, morbidity and mortality would be well-received. Thank you.

Patricia Rowan:

Thank you, Sarah.

Last but not least, Bonnie Zima?

Bonnie Zima:

I think there's two gaps. One is increasing detection of suicide risk with some type of indicators and a broad, timely follow-up.

The other that hasn't been brought up yet is use of the evidence-based suicide prevention interventions with priority in the ED. For both of these, I would suggest an age range starting at age greater than 12.

Patricia Rowan:

Okay, thank you so much, everyone. I could tell you all did your homework and thought about that overnight. I really appreciate your thoughtful sharing there.

At this point, we would like to provide an opportunity for public comment on gap areas, so let's go to the next slide. If any members of the public would like to make a comment on gap areas in the Child and Adult Core Sets, this is the opportunity to do so. Please use the "raise hand" feature in WebEx. We will call on you as we see hands going up.

I am not seeing any hands for public comment. Last call for public comment on gap areas.

All right, let's move – oops, I see Ramona. Ramona, if you wanted to make a comment, can you put your hand back up? I think we missed it. Let's unmute Ramona, Derek. Ramona, please state your name and affiliation if you can.

Ramona English:

Yes, I am Ramona English with NNOHA, National Network for Oral Health Access.

I just want to say thank you for the opportunity to be part of this meeting. I really enjoyed listening to the Workgroup members suggestions. I just wanted to give my plus one.

Definitely child and adolescent anxiety depression screening – ACEs, PCEs. Also from an oral health perspective, I still feel that we do need an integration measure that is focusing on the younger population if we are to really catch up with all the disease burden in our population. So maybe a dental visit before age 1 and then leave it to us to figure out the integration portion. Thank you.

Patricia Rowan:

Thank you, Ramona.

Any other public comment?

All right, let's move on to the next slide then.

Now we've come to the part of the meeting where we will do a little reflecting on future directions. Let's go to the next slide.

This slide has a really brief agenda for this part of the meeting. So, to begin, I'll recap the Workgroup's recommendations for updating the Core Sets.

Over the last two days, the Workgroup discussed eight measures including two measures that were suggested for removal and six measures that were suggested for addition. As Alli

mentioned earlier, in order for a measure to be recommended by the Workgroup for removal or addition, a measure required a "yes" vote from at least two-thirds of the Workgroup members.

Thank you to everyone for managing through the voting technology this year.

Of the two measures that were recommended for removal, the Workgroup voted not to recommend either of those measures. So, none of the measures that were suggested for removal were recommended for removal.

Of the six measures that were suggested for addition, the Workgroup recommended adding three of them to the Core Sets. Those measures were the: Evaluation of Hepatitis B and C, Initial Opioid Prescribing for Long Durations, and Adults with Diabetes – Oral Evaluation.

We also just now had a robust discussion about gap areas for the 2028 public Call for Measures. We'll use all that information as a team as we plan for the public Call for Measures, which will be later this calendar year.

One thing I do want to note. This came up – Lisa mentioned it in her comments – is that the public Call for Measures Process is the process for which all suggestions for measures to either remove or add come to the Workgroup's attention. Yesterday, we also had some discussion about – and today there was some discussion of how the Antibiotic Utilization for Respiratory Conditions measure was similar to existing measures.

We talked today about not wanting to add certain measures without removing them. So, I just wanted to take the opportunity to remind folks that when you go to submit measure suggestions, you can suggest measures both for removal and addition. That public call process is the only venue by which measures can be discussed by the Workgroup. Neither our team at Mathematica nor CMS bring measures to the Workgroup for discussion outside of that public call process.

Now we'll give the Workgroup an opportunity to reflect on the 2027 Core Sets review process. In the spirit of continuous quality improvement, we will also provide an opportunity to suggest ways that we can improve the process for next year. So please consider any suggestions in terms of this meeting or earlier meetings, the Call for Measures, or the resources that our team provides.

Workgroup members, we'll open it up for discussion for a few minutes on process improvement. Please use the "raise hand" feature, and we'll call on folks in the order that we see your hands up.

Jakenna, I see your hand up; but I think that might have been from earlier – okay.

Ben Anderson?

Benjamin Anderson:

Yes, hi, thank you. Really want to thank the Mathematica team for another excellent set of meetings this year. I also want to thank all of the other Workgroup members who, as usual, I think provided really thoughtful analysis and discussion. I do think that the discussion this year was really well-organized and facilitated. This is my third year on the Workgroup, and I think it's, in my opinion, the best year in terms of how the conversation was facilitated.

I do recall specifically last year when we were discussing the social drivers of health measure that there were a lot of questions asked but not answered, which I think contributed to us not having a measure on the Core Sets currently in the out years. I think the way that the discussion was facilitated was specific – callouts of questions to members or outside parties that might have additional information. I think that really contributed to the richness of the discussion, the thoughtfulness of the discussion. So just want to shout out that I noticed that and thought it worked really well and want to thank the team for that. Thanks.

Patricia Rowan:

Thank you, Ben. We appreciate the feedback.

Rachel?

Rachel La Croix:

My comments are probably somewhat related to Ben's. I knew – and I think you may have already answered the question just in terms of reminding us that the public Call for Measures is the venue or the way in which measures are identified for discussion at the meetings and that there's not really another way for measures to come onto the agenda for the review process.

I was thinking specifically about the social determinants screening measure that we discussed last year as well. I know we had had a really rich discussion. I know that – I think pretty much everybody in the Workgroup was very supportive of having a measure around that concept. But there had been a number of shortcomings and also just some uncertainty around the measure that had been suggested. So, I guess my kind of question would be is there a way that we would be able to come back and discuss some of those measures at future meetings, or would the way to do that be for someone to recommend one of those measures for addition again?

Because I know last year that some folks had started using the measure but didn't necessarily have a lot of data for it yet. So, we all had a lot of questions and were thinking we want a measure like this, but we're not sure it's ready yet. So just trying to think about how when we run across measures like that, how can we think about having additional conversations about them as they become more sophisticated and have more details available and as people build up more of an experience with using these types of measures.

Patricia Rowan:

I really appreciate the comment and the question, Rachel. You're right; that's really the venue or the mechanism for the Workgroup to discuss it again would be for somebody to resubmit either the same measure or a similar measure that would meet our criteria. It's a balance because we try not to talk about the same measures over and over unless there are changes in the specifications or, like you said, new data, new states to have experience with using the measure.

So, I think if more states are using it, there is more data on the implementation, the feasibility, resubmitting the measure for discussion or consideration is likely the best venue to do that. I hope that helps.

Jeff – I see Jeff's hand up. Jeff, do you want to go next?

Jeff Huebner:

Yeah, sure. Sorry if this is repetitive because I'm not sure if it's a question or a comment or if it gets back to how CMS outlines the process or something even in statute. But I do think, yeah, this issue came up a couple of times this Workgroup session around whether to potentially adopt – and I think it sounds like from the discussions we were having, some of us were contemplating whether we wanted to add a measure if something else wasn't removed, especially if there was overlap.

I definitely take your point about what the current process is; but I would just reflect back or wonder if maybe there is a way to call that out more to the people who do decide to submit a measure for removal or addition or other ways to improve the process.

Patricia Rowan:

Thanks, Jeff, we really appreciate the feedback; and we'll definitely be taking it back as a team.

Jakenna?

Jakenna Lebsock:

So, first, I want to say thank you to the Mathematica team for putting this together. I do think it was a really good year having done this for a few years now. I particularly appreciate the ability for the states to share their opinion and, in some instances, to have a dedicated time to go first. I'm not sure if there's more states this time or if there was just more active conversation, but I feel like the balance between state perspective and how it may work as well as other types of subject matter experts that came to the table was really strong this year.

So, I really appreciated those processes to hear the conversation as well as the work that the group did to be prepared to share their feedback and engage in the discussions throughout the two days.

Patricia Rowan:

Thanks, Jakenna. We're glad that that worked out well. Our Workgroup did grow a lot with an emphasis on these new folks from states, so I appreciate the feedback.

I see Ben's hand up. Ben, did you have something else to add; or is that just up from your previous comments?

Okay, I'm going to say it was from Ben's previous comments.

Any other comments from Workgroup members on process improvement opportunities?

I see Roshanda.

Roshanda Clemons:

Hi, thank you. I just wanted to again say thank you again to the Mathematica team for hosting, facilitating, and providing all the background information that we need. That's really helpful.

I also really appreciate – this is only my second year doing it, but it was really helpful just to have the various disciplines because even though we come with our own expertise, I think having the discussion from other perspectives is really helpful on helping us to make the appropriate decision.

Then also, again, thank you for reminding us that whoever makes suggestions for submissions that not only can they suggest additions but they can also suggest removals at the same time. Just wondering if the team – if they notice when individuals or groups make suggestions for submissions if they can remind them, if that's possible – I'm not sure in terms of legality aspect – if they can remind them that they're existing measures that can be replaced so that the group can have that option for voting for the more effective measure or at least removing a measure that doesn't seem to be effective without having to wait another year or so for that more effective impactful measure to be reintroduced.

But thank you for the entire Workgroup and again to the Mathematica team for your time.

Patricia Rowan:

Thank you, Roshanda, we appreciate the suggestion.

Laura?

Laura Boutwell:

Hi, yes, thank you. I want to echo everybody's thanks to the Mathematica team for the meeting. This is my first year on the Workgroup, so I really appreciated all of the materials and questions ahead of time in preparing for the meeting, as well as the robust conversation that was had with all of the Workgroup membersthat was really, really, really valuable.

I was wondering – I did appreciate the opportunity, especially as a new member, to have the practice voting that was done in advance. But I didn't know if it would be helpful for maybe just for new Workgroup members to have like a brief orientation – like 30 minutes, just the Workgroup to go over any technical things that might be helpful to troubleshoot for getting ready for one of these meetings, just from a purely technical perspective. I don't know if that's possible. But otherwise, it went well. I just – it might be helpful. Thank you.

Patricia Rowan:

Yeah, there's a bit of a learning curve. We recognize that and definitely appreciate the suggestion.

Kim?

Kim Elliott:

I really am appreciative of the process that we have in place right now. I think that the documentation and how it's put together for us to review and consider the measures strengthens every year. I really thank Mathematica for that.

Also, I think the process that you've put in place now where the states that have implemented a measure or are using a measure go first and describe their experience is extremely helpful. I think it helps other participants on the Workgroup better understand perhaps the barriers, the challenges, and what's really working in some of those states and how it impacts the states from a resource perspective or in evaluating quality of care, outcomes to care, and service delivery.

So overall, I just think that the process continues to improve every year; and thank you for that.

Patricia Rowan:

Thank you, Kim.

Angela Parker, I see your hand up.

Angela Parker:

Yes, thank you, this is also my first time in participating in this, and I really do appreciate all the conversation regarding it. To the point regarding the states – because I'm one of the states – and hearing what the others – the challenges in any of these measures and making sure that we're able to obtain the information and get the education out there, utilizing our MCOs and provider education associated with all these. I mean, I know providers look at this as well. So, I do appreciate the opportunity and the conversation.

I'm usually not one to add a measure unless we take one off. I would kind of look at what our current measures are, see how well we are performing as a – collectively to see whether or not those should be removed or not. But other than that, I appreciate it. It was a great two days!

Patricia Rowan:

I'm glad to hear that. We appreciate you being here and your contributions as well.

Great, we appreciate everybody's feedback. Our team takes it really seriously, I hope you know. We will take all these suggestions back as we plan for next year.

We will also be sending Workgroup members a post-meeting evaluation form and survey to fill out. So you'll hear from us again. If you think of anything else or would like to share any additional feedback anonymously, that's a good venue for doing that as well. Next slide.

At this point, we would like to have one last opportunity for public comment. If you would like to make a comment, please used the "raise hand" feature in the bottom-right of the Participant panel; and we will unmute you in turn.

All right, I'm not seeing any public comments. The thing I do want to reiterate – we got a question about this – is that there will be an opportunity for public comment on the draft report later this year. That will be another opportunity for folks to submit comments on the measures, on the Workgroup recommendations, the gap areas, et cetera. Next slide.

As we begin to wrap up, I'd like to extend our thanks again to Workgroup members for your flexibility and patience in conducting this meeting virtually. I know many of you had audio issues at one point or access issues with the voting platform. I just really want to thank you for sticking with us and working with our team to work through all of those issues. As I said, our Workgroup grew a lot this year; and for many people, it was their first experience.

These platforms are also making updates so even if you've been around for more than one year, everything is new again every year. So, we appreciate your flexibility. Next slide.

I'd like to give our co-chairs, Kim and Rachel, an opportunity to make any final remarks before we adjourn.

Rachel, I'll start with you.

Rachel La Croix:

Thank you. I'd just like to first echo everyone's thanks for the Mathematica team for all the preparation they did for this meeting and handling all of the logistics, providing all of the really comprehensive Measure Information Sheets, and really just helping us stay on track with a really well-organized meeting. I felt like everything flowed really, really well; and we were able to have really good, comprehensive discussions about all of the measures that were recommended for removal or for addition.

I also want to echo the comments folks made about how useful it was to be able to hear about all of the different states using some of the measures and their experiences with those measures – not just in terms of feasibility of collecting and reporting but also in terms of how to use the measures, whether for just internal checks of how things are going or for incentives or value-based purchasing or other purposes.

And then having the ability for other organizations and folks that are using these measures or able to speak to ways that these measures could be used during the public comment periods. All of that was really helpful and I think really contributed to our consideration of these measures in relation to the Core Sets.

So, I would just like thank everyone for all of their work and focus over the last couple of days. This has felt like a really productive meeting, and I feel like we came away with some really good, well thought-out recommendations. Thank you.

Patricia Rowan:

Thank you, Rachel.

Kim?

Kim Elliott:

I would go back to why we're doing the work that we do, and it really is all about the member – the member's experience, the quality of care that they're getting, the outcomes from the care that's being delivered. As I sat through the meeting the last two days, I was extremely appreciative – impressed, really, with the experience, the education, how informed all of the Workgroup members were about the different measures that were on the table for discussion, either for removal or for addition to the Core Sets.

I think that it led to a really robust discussion, and I do think that it provided an opportunity for perhaps even changing minds based on additional thoughts and perspectives that were brought by different Workgroup members on how we would vote on some of those measures for inclusion or to remove from the core measure set.

So, I think the process is fantastic. I thank everybody for all of the time and effort that they put in not only to recommend – make the recommendations for removal or addition, but it takes a lot of effort and time to really prepare for the meeting and all of the great resources that Mathematica has provided. Really makes that process so much easier for all of us, including all the links that they provide to different references regarding different studies and things like that that are related to those measures.

So, I think it's a great practice. I thank everybody for their time, effort, energy put into this and also for the great participation you had during the meeting. Everybody had an opportunity to provide feedback and comments. Everybody had as much time really as they needed to do so. I

think that has, as Rachel said, resulted in some really good, well thought-out recommendations for CMS to consider. So, thank you, everyone.

Patricia Rowan:

Thank you both. We appreciate your leadership through this journey as well. Next slide.

All right, so by now this slide probably looks pretty familiar. It has some key milestones for the review process this year. As you recall, our journey began back in August and continued with the January 15th webinar to get organized for this week's voting meeting. We're grateful for all of you that you've taken the time to prepare and spent the better part of two days with us.

Our next step is that our team will be reviewing and synthesizing the discussion that occurred over the last two days in order to prepare a draft report. The draft report, as I mentioned, will be made available for public comment. Workgroup members will have the opportunity to review and comment on the report during that public comment period, along with anyone else who would like to make a comment on the report.

Our team will then review the public comments and finalize the report for release. From there, CMS will take the report and obtain additional input from interested parties, including other federal agencies, state Medicaid and CHIP quality leaders and release their final updates to the 2027 Core Sets. Next slide.

If you ever have any questions about the Child and Adult Core Sets Annual Review process, you're always welcome to email the Mathematica team at the address that is shown here on this slide. Next slide.

Finally, one last thank you to the Workgroup members, federal liaisons, measure stewards, and public attendees for your attendance and contributions to the meeting this week. Thank you to everyone who contributed to the process. Again, another special shout-out for our team here at Mathematica. This meeting would not have been possible without everybody's help, flexibility, and resilience, and ability to pivot over this last couple of days.

We wish everyone well and now concluding the 2027 Child and Adult Core Sets Annual Review process. This meeting is now adjourned. Thanks, everyone.