2026 Child and Adult Core Sets Annual Review: Meeting to Review Measures for the 2026 Core Sets, Day 1 Transcript February 6, 2024, 11:00 AM – 3:45 PM ET

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I'm pleased to welcome you to the 2026 Child and Adult Core Sets Annual Review Meeting to Review Measures for the 2026 Core Sets, Day 1. 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 comments, please make sure that your audio is associated with your name in the platform.

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

Finally, closed captioning is available in the WebEx platform. To enable closed captioning, click on the CC icon in the lower-left corner of your screen. You can also click Ctrl-Shift-A on your keyboard to enable closed captioning. And with that, I will hand it over to Margo to get us started.

Margo Rosenbach:

Thank you, Talia. Hi, everyone. My name is Margo Rosenbach, and I'm a Vice President at Mathematica. I direct Mathematica's Quality Measurement and Improvement Technical Assistance Contract with the Center for Medicaid and CHIP Services. It's my pleasure to welcome you to the 2026 review of the Child and Adult Core Sets. Thank you to our Workgroup members, federal colleagues, and members of the public for joining us for this virtual meeting. Next slide, please.

I wanted to take a moment to acknowledge my colleagues at Mathematica who are listed here. This has truly been a team effort to prepare for the meeting in terms of both content and logistics. I also want to acknowledge our colleagues at Aurrera Health Group, who will be helping to write the report, summarizing the Workgroup discussion and recommendations. Next slide.

We have a full agenda and important objectives to accomplish over the next two days, and our four meeting objectives are listed on this slide. First, the Workgroup will discuss the two measures that were suggested for removal and the two measures suggested for addition to the

Child and Adult Core Sets. Second, the Workgroup will vote on the measures suggested for removal or addition and make recommendations for updates to the 2026 Core Sets. Third, the Workgroup will discuss priority gap areas in the Core Sets and criteria for the 2027 Public Call for Measures. This discussion will take place on the second day of the meeting. Before we wrap up today, I will preview our plan for this discussion. And finally, we'll provide multiple opportunities for public comment over the next two days to inform the Workgroup discussion. As you may have noticed, we have a shorter agenda for tomorrow and expect to end around 2:30 p.m. Eastern rather than 4:00 p.m. as originally planned.

I'd like to pause for a moment and note that we're committed to a robust, rigorous, and transparent meeting process despite the virtual format. That said, we acknowledge that attendees may experience challenges with the virtual meeting format. I hope everyone will be patient as we all do our best to adhere to the agenda and fulfill the objectives of this meeting. Some of you may be wondering why we're not using video for this meeting. As we've mentioned in the past few years, we found that some individuals in some locations do not have sufficient internet or Wi-Fi bandwidth to support video. To ensure full participation by Workgroup members and the public, we want to mitigate the technical difficulties that sometimes arise with using video.

I also wanted to remind the Workgroup members of a few ground rules for participation today. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a Workgroup, however, you are charged with recommending Core Set updates as stewards of the Medicaid and CHIP program as a whole and not from your own individual or organizational perspectives. Please keep this in mind during the discussion and voting. Second, we know that spending up to five hours a day in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning from breaks so that we can have everyone present for the discussion and voting. And related to that, we want to make sure that all Workgroup members who wish to speak may do so. This platform will enable you to unmute yourself when you want to make a comment or ask a question. As Talia mentioned earlier, please raise your hand if you would like to speak; or contact us through the Slido Q&A feature if you are having technical difficulties. We will make sure you have a chance to speak before we move on. Finally, we want to remind public attendees that we will have designated opportunities for public comment and ask that you save your comments until we reach the public comment period. Also, please note that we will not be accepting public comment through the Q&A feature.

Now I'd like to turn to our co-chairs, Kim Elliott and Rachel La Croix, to offer their welcome remarks. Next slide.

Kim, would you like to go first?

Kim Elliott:

[Inaudible] … and I'm very happy to be with all of you again today for this very important meeting. I'm really very interested in some of the discussion today -- and of course tomorrow as well -- but today, focused on the different measures that have been proposed for addition and removal from the Core Set. I think that the discussion should be lively, as it always is; and I am very interested in hearing all of your expert opinions and thoughts on that matter. Tomorrow, I'm really looking forward to the discussion on the gaps. That's going to be very informative for all of the future work that we have to do. Just thank everybody, including the Mathematica people and all of our partners on the line that bring so much value and importance to the work that's being

done to really improve the outcomes in care and services delivered to the Medicaid population. Rachel, I'll turn it over to you.

Rachel La Croix:

Thanks, Kim. Can you hear me?

Margo Rosenbach:

Yes, we can.

Rachel La Croix:

Okay, great, thank you. Good morning, everyone. I echo Kim's welcome and thank everybody for their thoughtful suggestions for removals and additions this year and look forward to having a robust conversation with everybody regarding theirs. As we mentioned, I believe in some of the prep meetings for this, I do feel like our having a smaller number of recommended additions and removals this year is kind of reflecting the stability of the Core Set over time and a lot of the prior discussions we've had about priority areas before. But thank you, everyone, for all the preparation you've made looking at these proposed changes and preparing for our conversations today. Thank you also, just to echo Kim's thanks, to the Mathematica and CMS teams for all the work that went into preparing materials and the structure of this meeting, and just look forward to the discussion we're going to have over the next couple of days. Thank you.

Margo Rosenbach:

Thanks, Kim and Rachel. Thank you for serving as our co-chairs and for making these remarks. Next slide, please.

So now we'll introduce the Workgroup members and any disclosure of interests. Next slide.

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

When we go through the roll call, we ask that Workgroup members raise their hand when their name is called. You will hear a tone when you have been unmuted by the event producer. Please ensure you are also not muted on your headset or phone. When we unmute you, you can say hello; share any disclosures you may have or indicate that you have nothing to disclose. When you are done, please mute yourself in the platform and lower your hand. When you would like to speak later during the meeting, raise your hand and we'll unmute you. Next slide.

On the next three slides, we have listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand so we can unmute you. If you have any technical issues, please use the Slido Q&A function for assistance. Kim, starting with you, please indicate whether you have a disclosure.

Kim Elliott:

Hi, this is Kim; and I have nothing to disclose. Thank you.

Margo Rosenbach:

Rachel La Croix? Rachel, are you...?

Rachel La Croix:

Yes, sorry, I was muted. I have nothing to disclose.

Margo Rosenbach:

Thank you. Ben Anderson?

Ben Anderson:

No disclosures.

Margo Rosenbach:

Thank you. Rich Antonelli? Rich, you are unmuted.

Rich Antonelli:

Yes, I am unmuted. How about now?

Margo Rosenbach:

Yes, we can hear you.

Rich Antonelli:

Yes, good morning, everybody. I have no disclosures.

Margo Rosenbach:

Stacey Bartell?

Stacey Bartell:

Hello, I have no disclosures.

Margo Rosenbach:

Tricia Brooks? I don’t see Tricia. We’ll come back to Tricia later. Emily Brown?

Emily Brown:

Good morning, Emily Brown, no disclosures.

Margo Rosenbach:

Great. Joy Burkhard?

Joy Burkhard:

This is Joy Burkhard. I think it's my turn. I'll go ahead and say hello, and I have no financial disclosures. Thank you.

Margo Rosenbach:

Thank you. Stacey Carpenter? Stacey, you should be unmuted.

Stacey Carpenter:

Oh, I thought you could hear me. Good morning, everyone. I have no disclosures.

Margo Rosenbach:

Thank you. Roshanda Clemons? I don't see Roshanda, so we'll come back later. Next, Lindsay Cogan. I don't see Lindsay – ah, now I do. Lindsay, you're up.

Lindsay Cogan:

I have no disclosures.

Margo Rosenbach:

Great, thank you. Jim Crall? Jim, you should be unmuted.

Jim Crall:

Oh, sorry, Margo. It broke up right when you said my name I think. Yes, Jim Crall, UCLA. On the form I noted that I do some consulting for Centene and Georgetown University, mentioned some travel reimbursement expenses from the Dental Quality Alliance, and noted that my wife owned some Elevance stock which she inherited. But I don't believe there are any conflicts with any of the measures here.

Margo Rosenbach:

Thank you, Jim. Erica David Park? I don't see Erica at the moment. I think Erica is coming late today. Next slide.

All right, Anne Edwards?

Anne Edwards:

Good morning, everyone, no conflicts.

Margo Rosenbach:

Thank you. Clara Filice? Clara, you should be unmuted.

Clara Filice:

Hello, this is Clara. I have no disclosures, thank you.

Margo Rosenbach:

Thank you. Angela Filzen?

Angela Filzen:

Good morning, everyone. I have no disclosures.

Margo Rosenbach:

Thank you. Sara Hackbart? Sara, you should be unmuted.

Sara Hackbart:

Good morning. I have no disclosures to report.

Margo Rosenbach:

Thank you. Richard Holaday?

Richard Holaday:

Good morning and no disclosures, thank you.

Margo Rosenbach:

Thank you. Jeff Huebner? Jeff, you look like you just were muted again. There you go.

Jeff Huebner:

Good morning. I'm Jeff Huebner, yeah no disclosures. Thank you.

Margo Rosenbach:

Thank you. Sarah Johnson let us know she could not attend today and tomorrow. David Kelley?

David Kelley:

I will disclose that I'm part of NCQA's Committee for Performance Measurement and in the past have reviewed LTSS measures for Yale and have received no monetary compensation from either of those organizations. Thank you.

Margo Rosenbach:

Thanks, David. David Kroll?

David Kroll:

Hi, everybody. No disclosures, thanks.

Margo Rosenbach:

Thank you. Jakenna Lebsock? Jakenna, you should be unmuted.

Jakenna Lebsock:

Okay, can you hear me now?

Margo Rosenbach:

Now we can, yes.

Jakenna Lebsock:

Okay, good morning, everyone. Jakenna Lebsock – my disclosures are that I do serve as a board member for ADvancing States, but I am not here in that capacity, nor have I had any conversations with the ADvancing States team regarding their priorities. Then also, my team did receive a grant for the Viral Load Suppression measure over the last two years to work on building that out in our reporting capacity within Arizona – so just sharing those two things.

Margo Rosenbach:

Thank you. Hannah Lee-Brown?

Hannah Lee-Brown:

Good morning. I have nothing to disclose, thanks.

Margo Rosenbach:

Thank you. Next slide, please. Katherine Leyba, you should be unmuted. Katherine? Derek, can you unmute Katherine? Yes, there you go.

We still can't hear you if you're speaking. Katherine, you look unmuted on the platform. Are you possibly double-muted? Katherine?

Lisa Patton:

Hi, Margo. Hi, everyone. Thank you, no disclosures to report.

Margo Rosenbach:

Great, thank you. Lisa Patton?

Lisa Patton:

Oh, apologies, Margo. That was me. That was Lisa Patton. I just—

Margo Rosenbach:

Oh, thank you. Okay so, Katherine, were you able to speak? Still no Katherine; but I can see her, and I can see she's unmuted. So maybe she is double-muted. We'll come back.

Laura Pennington? I think Laura might be late today.

Grant Rich? I don't see Grant Rich.

Lisa Satterfield? Lisa, you should be unmuted now. Lisa, could you be double-muted? Let's go back to Grant Rich. I see you, Grant.

Grant Rich:

Can you hear me?

Margo Rosenbach:

Now we can, yes, thank you. Glad to have you.

Grant Rich:

Yes, I have no disclosures. That's all.

Margo Rosenbach:

Thank you. Lisa, can you try again on the unmuting?

Lisa Satterfield:

Hello, this is Lisa.

Margo Rosenbach:

We can hear you now. Any disclosures?

Lisa Satterfield:

No disclosures, thank you.

Margo Rosenbach:

Great, thank you. Linette Scott?

Linette Scott:

Happy to be here. No disclosures to report, thank you.

Margo Rosenbach:

Thank you. Bonnie Silva?

Bonnie Silva:

Good morning. I also sit on the Board of ADvancing States. I have not talked to them about their priorities. I don't think there's anything to disclose there, and I do not have any other financial interests in these measures. Thank you.

Margo Rosenbach:

Thank you. Kai Tao? Kai, I think I see you. Can you raise your hand? There we go.

Derek, can you unmute Kai?

Kai Tao:

I don't need it. Good morning, this is Kai Tao. I do not have any disclosures, thank you.

Margo Rosenbach:

Thank you. Ann Zerr? You should be unmuted. Ann Zerr, can you raise your hand again so we can unmute you? Oh, it looks like you might have – there you go, okay.

Derek, can you unmute Ann?

Ann Zerr:

I have no disclosures.

Margo Rosenbach:

Okay, thank you. And finally, Bonnie Zima? Bonnie, you should be unmuted.

Bonnie Zima:

Good morning, no disclosures.

Margo Rosenbach:

Thank you. I believe we have Tricia Brooks on now. Tricia, can you raise your hand and we'll unmute you?

Tricia Brooks:

Can you hear me?

Margo Rosenbach:

Yes, we can.

Tricia Brooks:

Okay, and I'm here, no disclosures.

Margo Rosenbach:

Thank you. Kathy Leyba? You're good, okay.

Alright well, I think that is our roll call and our muting and unmuting process. Thank you, everyone, for bearing with us. A reminder...when you wish to speak, raise your hand. We will call on you and unmute you. Thank you. All right, next slide, please.

So now we turn to our federal liaisons who are listed here. The federal liaisons are non-voting members. I'll read the name of the agencies but not do an individual roll call. We have Agency for Healthcare Research and Quality, Center for Clinical Standards and Quality, Centers for Disease Control and Prevention, Health Resources and Services Administration, Indian Health Service, Office of the Assistant Secretary for Planning and Evaluation, Office of Disease Prevention and Health Promotion, Substance Abuse and Mental Health Services Administration, and U.S. Department of Veteran Affairs. Federal liaisons, if you have questions or comments during the Workgroup discussion, please raise your hand and we will unmute you.

I'd also like to take the opportunity to thank our colleagues in the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services and also the measure stewards who are attending and available to answer questions about their measures. Next slide, please.

With that, I would now like to introduce Deirdra Stockmann, the Director of the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services, who will make some welcome remarks on behalf of CMCS. Deirdra, the floor is yours.

Deirdra Stockmann:

Thank you, Margo. Good morning, everyone. It was fun to listen to all of your voices coming to us from across the country. I am really thrilled to join my colleagues in welcoming you to the 2026 Core Set Annual Review Meeting. Welcome to our Workgroup members, the chairs, the many federal partners, and members of the public. Your being here today shows that you are among many who think about and work to improve the quality of care delivered to the 85 million people, children and adults, enrolled in Medicaid and CHIP. For that, we are grateful. It is not hyperbole to say, as I do every year, that we look forward to this meeting with great anticipation and excitement. We look forward to it because it is a rich opportunity to connect with all of you, to collect your wisdom, insight, and input into how we can continue to strengthen the Child and Adult Core Sets and how we can further our goal of using measurement to inform and support efforts to improve the quality of care, health outcomes, and to advance equity.

The entire annual Core Set review process, the content of this meeting, and the resulting recommendations are part of the critical infrastructure of the Medicaid and CHIP Quality Program. Through years of thoughtful Workgroup input and public comment, the Core Sets have become really widely recognized as well-vetted, concise sets of measures that capture important representative aspects of quality of care in Medicaid and CHIP. As has been mentioned, as Rachel alluded to earlier, the Core Sets are very strong now; and they're works in progress always. We revisit them every year partly because we have a statutory requirement to do that, but mostly because as the measurement field evolves and new and better measures emerge, as health care needs and priorities shift over time, we must continue to review and refine the Core Sets so that they remain relevant and useful.

One example of evolution in the measurement field that I know many of us are spending a lot of time thinking about lately is the shift to digital measurement. We're excited about the potential a digital-first measurement future has for our ability to ascertain quality of care and health outcomes information, and we're daunted by the data infrastructure and data flow challenges that that shift will present to health systems, providers, and states. But we know it's something that's happening. It's going to change likely substantially over the next several years. Without getting further into the weeds on digital measurement or any other examples of changes happening in the measurement field today that affect our quality measurement needs, the point is that the Core Sets and how we do quality measurement need to be able to adapt. This annual review process is a critical piece of that.

While our time today and tomorrow will focus on potential updates to the 2026 Core Sets, I must take a moment to talk about this year, 2024. 2024 is a big year for Child and Adult Core Sets because this fall, all states will report on the Child Core Set and the behavioral health measures in the Adult Core Set as mandatory reporting goes into effect. My key message on mandatory reporting today is that we are here to support states to be successful at meeting the mandatory reporting requirement. CMS and states have been gearing up for this moment for a long time, and states are well along the way preparing for the transition to mandatory reporting because you've all been working hard over the last many years to build reporting capacity, collect measures, submit data to CMS. The number of states reporting voluntarily and the numbers of measures reported by states have increased steadily in the last few years.

A few months ago, we released the data on Core Set reporting for fiscal years 2021 and 2022. So just to highlight, for fiscal year 2022, 50 states reported at least half of the Child Core Set measures; and CMS was able to publicly report data on 24 out of 25 Child Core Set measures. On the adult side, 47 states reported at least half of the Adult Core Set measures; and CMS was able to publicly report on 29 of 33 measures. So that is the most robust voluntary reporting to date, and it's thanks to the hard work of many of you joining today. We're moving in the right direction. We have a few more reporting gaps to close before the fall. So again, I want to emphasize that the Core Set Technical Assistance Team here at CMS, with the great support of the Mathematica team, is standing ready to help states throughout this year to prepare to submit data in the fall for the 2024 Core Sets. Do not hesitate to reach out for help. We have lots of technical assistance already underway, lots more planned; and we want to hear from you about what else you need. So that's it on 2024.

I'll close and move back to the charge to make recommendations for updates to the 2026 Core Sets. Those of you who have done this with us for a few years know we're always jumping back and forth in our minds from year to year as we think about the Core Sets. So coming back to 2026, we're all here to do valuable work, work that is vital to the Medicaid and CHIP program and important to the lives of the millions of people served by our programs.

Thank you for showing up. Thank you for doing your homework. Thank you in advance for the rich and thoughtful discussion that's motivated by our shared commitment to measuring, monitoring, and improving the quality of care delivered to people in Medicaid and CHIP, and ultimately to improving health outcomes an equity in our country. Very finally, a heartfelt thanks to the Division of Quality and Health Outcomes Core Set Team led by Gigi Raney and the Mathematica Core Set Review Team led by Margo Rosenbach for the hard work and thought that goes into making this such a successful meeting. Let's get into it! Thank you.

Margo Rosenbach:

Thanks, Deirdra, for your rousing comments about where we are and where we're headed. This is very exciting! Before we move on to hear from Alli and Gigi, I just wanted to go back and acknowledge Roshanda Clemons. Roshanda, there you go. Can you introduce yourself and any disclosures?

Roshanda Clemons:

Good morning, everyone. I hope everyone can hear me now. I just wanted to let you know I have no disclosures, thank you.

Margo Rosenbach:

Thank you so much. We're getting the hang of the muting and unmuting as the meeting goes on.

All right, so let's move along. I think that Deirdra might have stolen some of Alli's key talking points, but she'll provide some additional information about the Child and Adult Core Sets and then turn it over to Gigi Raney from CMCS to share some information about mandatory reporting of the 2026 Child and Adult Core Sets. Alli, it's all yours.

Alli Steiner:

All right, thanks, Margo. All right, so I'm going to share some information about the Core Sets to provide high-level context for the measure discussions occurring today and tomorrow. Next slide, please.

This slide shows results of voluntary reporting of the 2022 Child and Adult Core Sets. For FFY 2022 reporting, states reported a median of 21.5 measures out of 25 in the Child Core Set and 26 out of 33 measures in the Adult Core Set. Like Deirdra said, almost all measures met the criteria for public reporting, meaning they were reported by at least 25 states and met CMS standards for data quality. Reporting was very robust this year with 40 states reporting more measures for FFY 2022 than they did for FFY 2021 for both the Child and Adult Core Sets. As you would expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data. Less frequently reported measures include those with medical record extractions, electronic health records, or survey data collection. Not surprisingly, it often takes a year or two for states to ramp up for reporting new measures, although we do want to point out that there were several first-year measures for FFY 2022 that met the criteria for public reporting, which suggests that the new measures recommended by the Workgroup are both feasible and desirable for states. I'll talk about this a little bit more in the next slide. So, next slide, please.

This next slide shows the number of states reporting the FFY 2022 Child Core Set measures. As you can see, there is a wide range in the number of states reporting each measure. The two measures at the top of the slide are calculated by CMCS on behalf of states using CDC WONDER data. At the bottom of the slide, the Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure did not have enough states reporting for data to be publicly reported. All other measures were publicly reported for FFY 2022.

Notably, there were four measures that were new to the 2022 Core Set and met the threshold for public reporting their first year. These include Follow Up After ED Visit for Alcohol or Other Drug Abuse and Dependence, Follow up after ED Visit for Mental Illness, Oral Evaluation, Dental Services, and Topical Fluoride for Children. Next slide.

This slide shows the number of states voluntarily reporting each of the 2022 Adult Core Set measures. As with the Child Core Set, you can see there's a wide range in the number of states reporting each measure. Notably, the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure was a first-year measure for FFY 2022 reporting and met the threshold for public reporting. The four measures on the bottom of the slide did not have enough states reporting for the data to be publicly reported. Two of the measures are behavioral health measures that are subject to mandatory reporting for FFY 2024. That includes Screening for Depression and Follow-Up Plan: Age 18 and Older and Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control. The two other measures are Colorectal Cancer Screening and HIV Viral Load Suppression. Colorectal Cancer Screening was newly added to the 2022 Core Set and just missed the threshold for public reporting. We also wanted to note that HRSA is sponsoring a technical assistance effort to help states build capacity to calculate and report the HIV Viral Load Suppression measure as part of the Adult Core Set. Next slide, please.

Turning to 2024, the 2024 Child Core Set includes 27 measures, and the Adult Core Set includes 33 measures. The 2024 Child and Adult Core Set measure lists are available at the link on the slide.

This slide lists the seven Core Set domains, and we want you to keep in mind that CMCS will assign the domains when updating the Core Sets for 2026 and we'll not be focusing on domain assignments during the meeting.

We also wanted to note that some measures cut across the Child and Adult Core Sets, and CMCS decides which Core Set to assign the measures to. As we've mentioned in the past, CMCS does not have a target number of Core Set measures, either minimum or maximum. So over the next two days, we encourage Workgroup members to consider each measure on its own merits according to the criteria. Next slide, please.

I'd like to now briefly describe some potential upcoming changes to the Child and Adult Core Sets based on recommendations of the 2025 Annual Review Workgroup. The Workgroup recommended two measures for addition to the 2025 Core Set, which include Oral Evaluation During Pregnancy and Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults. The Workgroup did not recommend any measures for removal. Next slide, please.

The Workgroup also reconsidered three measures that use Electronic Clinical Data Systems, or ECDS, reporting. Prior Workgroups had recommended these measures for addition to the Core Sets, but CMCS deferred a decision pending further assessment of how the proprietary nature of the ECDS reporting method could affect the feasibility and variability of the measures for state-level reporting in the Core Sets. The Workgroup affirmed support for adding the following three ECDS measures to the Child and Adult Core Sets. That includes Postpartum Depression Screening and Follow-Up, Prenatal Immunization Status, and Adult Immunization Status. CMS is currently reviewing the Workgroup's recommendation and gathering input, and expects to release the 2025 Child and Adult Core Sets this spring. Next slide, please.

Increasing stratification of Core Sets measures is a priority area for CMCS. There's broad agreement that Core Set data reported at the aggregate state level can mask differences by subpopulations. However, stratified data can help identify disparities and identify quality improvement initiatives. For the FFY 2024 Core Set reporting cycle, which will occur this fall, states have the option to report Core Set measures by several stratification categories. This includes race, ethnicity, sex, and geography. For the FFY 2025 Core Set reporting cycle, states will be required to report data stratified by race, ethnicity, sex, and geography for a subset of mandatory measures. The link on the slide has more information on the requirements for FFY 2025, including a list of measures that will require stratified reporting for FFY 2025. This information is also available in the December 2023 State Health Official letter, which is linked on this slide. Next slide, please.

Now I'd like to introduce Virginia Raney, the Technical Director in the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services to make some remarks on behalf of CMCS about the requirements for 2026 Core Set mandatory reporting. Gigi, the floor is yours.

Virginia Raney:

Thanks, Alli. Can you hear me?

Alli Steiner:

Yes.

Virginia Raney:

Great, thank you. As we spend the next couple of days talking about the 2026 Core Sets, I wanted to spend a few minutes walking the Workgroup through the requirements for mandatory reporting for the 2026 Core Sets as we recognize that there's a lot of time travel that goes on in the Core Sets and things can get a little confusing.

Thank you, Alli, for walking us through what the requirements and decisions for 2025 were. I want to start with things that don't change from when reporting becomes mandatory in 2024 until our 2026 reporting. We are excited to say that there will be no new reporting system to learn to report the Core Set measures. We will be using the Quality Measure Reporting system that states are already familiar with. As covered in the Core Set final rule and in the initial mandatory reporting guidance State Health Official letter, or SHO, states are required to report on all of the measures on the Child Core Set and all of the behavioral health measures on the Adult Core Set. That does not change. Additionally, states must also adhere to the guidance detailed in the resource manuals and technical assistance briefs issued by CMS, which include how to calculate and report to CMS the Core Set measures data.

Moving on to things that do change, these things will be included in the 2026 CMS State Health Official letter, which we would expect to be released within the next calendar year. That letter will be informed in part by the final report of this Workgroup; and it will include the updated measure list for the 2026 Child and Adult Core Sets. It will include any populations for whom reporting is not required for a specific year because of the difficulties that states face in reporting data on that population. It will also include the final list of measures required to be stratified for 2026 and the categories by which they must be stratified. As outlined in the Core Set final rule, to allow time to improve the quality and completeness of data needed to stratify measures, the percentage of mandatory measures for which stratification will be required will increase over time until stratification is performed for all eligible mandatory measures beginning with 2028 Core Set reporting. In determining which measures states must report, CMS considers whether stratification can be accomplished based on valid statistical methods and without risking a violation of beneficiary privacy, or for measures obtained from surveys, whether the original instrument collects the variables necessary to stratify the measure. States are not required to report stratified data in 2024, the first year of mandatory reporting, though they can. It's always an option in QMR. But they will be required to report stratified data for 25% of eligible mandatory measures beginning with 2025 Core Set reporting. CMS identified the 25% of measures required for 2025 reporting in the initial mandatory reporting State Health Official letter.

For reporting in 2026, which is the focus of this Workgroup, the percentage of mandatory measures for which stratification will be required will increase to 50% of eligible mandatory measures. CMS plans to use the list of measures included in that initial SHO as requiring stratification in 2025 and to add to that list to meet the 50% threshold for 2026 reporting, building on the work that states are already doing to stratify measures. While the categories for measure stratification have not yet been finalized for 2026 Core Set reporting, it will be at minimum the categories that are required for 2025 stratification. As Alli noted earlier, for 2025 Core Set reporting, measures are expected to be stratified by three separate categories using established data standards. Those are race and ethnicity, sex, and geography. We know this is a lot, and we appreciate all the work that each of you and our state partners have already done to prepare for mandatory reporting. We are here to provide technical assistance and support to you now and in the future years. That's 2026 reporting requirements in a nutshell, and I'm going to turn it over to Margo. Thank you.

Margo Rosenbach:

Thanks, Alli and Gigi, for the time travel from ’22, to ’24, to ’25. Now here we are back in 2026. With that – next slide, please – we’d like to open it up for questions from Workgroup members. If you would have a question, please raise your hand; and we will unmute you. Please keep in mind that we’d like to focus on 2026. Any questions from Workgroup members? Lindsay Cogan.

Lindsay Cogan:

I just think it’s a good opportunity. I happen to live this every day, but often folks don’t. So when you say – and I apologize if you did this already, but I do think it’s important to note. When you say that we are talking about the 2026 Core Sets, that actually is services that were incurred in measurement year 2025, correct?

Margo Rosenbach:

That is correct, Lindsay. Thank you for pointing that out. That was all part of the time travel.

Lindsay Cogan:

It’s confusing, yeah.

Margo Rosenbach:

Yes, and some measures do have lookbacks to earlier periods, as you know. But in general, it is the measurement year 2025.

Any other comments, Lindsay? Anything else you wanted to add?

Lindsay Cogan:

No, I just really think it’s good to kind of level set there for folks who maybe don’t live this whole year thing in everything they do.

Margo Rosenbach:

Yeah, and I’ll just add also, Lindsay, that – and I think most people recognize this – it’s hard to set your watch by the time of the year that these meetings are being held. Some people thought, “How come we’re not meeting in April?” Well, it is February; and the reason we’re meeting in February is so that CMS can accelerate the process working collaboratively with other partners to update the Core Sets earlier so that the measures that are subject to mandatory reporting, as well as voluntary reporting, are released earlier and that the technical assistance resources are also available earlier.

A lot of people thought that this – usually we meet a little bit later in the year, and that is why – is so that CMS can be responsive to state needs and desires to have the information earlier.

David Kelley, you’re next.

David Kelley:

Thanks, just a question for 2026. At what point in time will decisions about previously voted upon ECDS measures – will we see a decision there and then recommendations from last year

about the dental measures? When will there be some type of decision and/or resolution of those previously recommended measures for 2026?

Margo Rosenbach:

Yeah, so for 2025 updates, I think Gigi might have mentioned CMS is actively working on the State Health Official letter that will come out for 2025. That should be coming out early spring or so. I think you can anticipate seeing the updates in that next State Health Official letter. Anything else, David?

David Kelley:

No, thank you, appreciate that.

Margo Rosenbach:

Great, thank you. Joy Burkhard, you're next.

Joy Burkhard:

Hi there. Just wanted to make sure I'm understanding reportable – that framing in the right way. I think Deirdra and Talia both hit on this – that there were some measures that were recommended and included in Core Sets thus far that aren't reportable; and that's because they don't meet thresholds for a number of states or overall encounters if you will. Is that accurate? Am I recapping that for myself correctly?

Margo Rosenbach:

So, to clarify, the public reporting of Child and Adult Core Set measures apply to measures that were reported by at least 25 states and that met CMS standards of data quality. So, I think you might have seen on one of Alli's charts that the CDF measure – Depression Screening and Follow-Up measure – was not reported by 25 states and therefore would not have been publicly reported. Does that answer your question?

Joy Burkhard:

It does help. Then for purposes of this Workgroup, we're not necessarily needing to worry about that. We're making recommendations on what should be in the Core Set and whether or not those thresholds are met are not for us to be concerned with. Is that accurate?

Margo Rosenbach:

The way I would frame that, when we get to the criteria – I believe Caitlyn will be presenting those criteria shortly – what you will see is the criterion that we suggest the Workgroup keep in mind, among many other criteria, so there's a lot of criteria, but one of them being that all states would be able to report a measure within two years of being added to the Core Sets. The reason for that, we want to take into account the balance; and again, Caitlyn will present our little Venn diagram of desirability, feasibility, and viability, that want to make sure that measures that are added to the Core Sets kind of optimize desirability, feasibility, and viability for states to be able to report the measures.

Joy Burkhard:

That's helpful. I think a bit of chicken and egg always at play with these dynamics, right? If it's not required, we may not test whether states can easily report. But I appreciate that, Margo. Thank you so much, that's what I needed.

Margo Rosenbach:

Sure, and I think that's one of the benefits of the diversity of the Workgroup because lots of opportunities to get different perspectives. As Lindsay said, she lives it every day; so, she and many other people on the Workgroup have very good insights that balance all of these considerations. So, thank you for that question, Joy.

Joy Burkhard:

Great, thank you.

Margo Rosenbach:

Other questions from Workgroup members? Rich Antonelli? You should be unmuted, Rich.

Rich Antonelli:

Yes, can you hear me, Margo?

Margo Rosenbach:

Yes, we can, thank you.

Rich Antonelli:

Great, as somebody that's been part of this group for several years, it is absolutely worth celebrating the trajectory, especially as we move toward stratification. Just sincerest thanks to everyone. At the risk of implying a question – what's next, what's next – I will go ahead and ask it anyway. One of the things that I personally would like to see are eventually the identification of and inclusion of disability standards. Being a pediatrician, in particular for children, but broadly Any projection how far out from the basic stratifying elements that we've heard about today and that were in the state health official letter – before we'll be identifying disability standards for inclusion and stratification?

Margo Rosenbach:

Thanks for your comments, Rich. It's always wonderful to hear your voice and your championing of stratification. To my knowledge, there is no time frame related to disability. Lots of work to be done to define disability in a standardized way for purposes of Core Set stratification. But what I would say is duly noted and will be reflected in the Workgroup report that there was a comment related to moving toward stratification by disability status.

Rich Antonelli:

Thank you, thank you so much.

Margo Rosenbach:

Sure. All right, Kim Elliott, you're next.

Kim Elliott:

Thank you, Margo.

Rich, that is really good and very important feedback; so, thank you for saying that. I'm just really struck when we have these meetings start where just a few years ago we were really questioning whether states could report administrative measures, had enough data and resources to be able to do it. Then it became the hybrid discussion; and now, of course, we're all the way into the ECDS digital measures and of course the stratification – which really shows all of the efforts that everyone puts into this work, where we're finally getting to the point where we're really focusing almost on the outcomes and what we can do to really drive outcomes and improve quality when we're talking about stratification by race, ethnicity, sex, geography.

So, I just think it really needs to be highlighted that this Workgroup, and with the support of course and direction from Mathematica and others, have really focused it down to where it's becoming so incredibly meaningful.

Margo Rosenbach:

Thanks, Kim. I also would like at this point to add the effort of states. It is a lot of work; and I think CMS appreciates and recognizes all the work, and certainly the Mathematica Technical Assistance and Technical Support Team understands just how much work goes into this. Once you start talking about stratification, it's even more work. When you talk about digital, lots of new frontiers for that. So, I just want to shout out to states for all of this hard work that states are doing.

I want to also acknowledge that when we're winding down tomorrow, we always have an opportunity for the Workgroup to talk about technical assistance. But in preparing for this meeting, I was reflecting on this year technical assistance is even more salient, I think, as the stakes are higher. We're in the mandatory phase – all of this being kind of heightened in terms of the awareness of what the needs and the requirements are.

So, as you're talking today and tomorrow and preparing for the wrap-up tomorrow, definitely be thinking more about what the technical assistance needs are for states to achieve the goals and requirements of mandatory reporting. Other comments/questions? Joy Burkhard?

Joy Burkhard:

Yes, hi, one broader question, Margo – let me know if this is something I should save for later or a comment session – is I had heard from state Medicaid agencies that one frustration with some of these Core Set measures and other measures are that we don't yet measure outcomes – that we're still just in process measures with most HEDIS and other measures. I just wanted to reflect that back. If there's anyone that can comment on sort of strategy overall around improving outcomes rather than just tracking process, I would love to hear about that at some point – perhaps tomorrow at the conclusion.

Margo Rosenbach:

Yes, Joy, thank you. When we do a preview later today about the Public Call for Measures conversation, about priority gap areas and criteria, would certainly love for you all to be thinking overnight and into tomorrow about future directions for the Core Sets -- keeping in mind what all of the criteria are currently and recommendations for updating the criteria. I think that certainly

one good thing to reflect on are outcome measures that are desirable, feasible, and viable and future directions of the Core Sets. So, thank you for raising that, and certainly be keeping that in mind when you get your opportunity to be talking about your one most important priority gap area tomorrow. But we'll come back to that at the end of the day. Other comments/questions? Last call before we move on.

All right, well, why don't we move on. At this point, thank you all for your questions and comments. We're going to start the measure discussion shortly. But first, we'll describe the approach to the measure review and do some practice voting. So now I'd like to turn it over to Caitlyn Newhard.

Caitlyn Newhard:

Thank you, Margo. Next slide.

I'll provide a quick recap of this information because most of us were together last month during the Workgroup meeting to prepare for voting. But for folks who might be seeing this for the first time, the slides and other background materials are available on our website. The Core Sets are a critical tool for understanding and advancing health care access, quality, and equity in Medicaid and CHIP. The Core Sets help CMCS and states identify disparities in care and to develop focused quality improvement efforts to advance health equity. The Workgroup's charge over the next two days is to assess and recommend measures for removal and addition in order to strengthen and improve the Core Sets. Next slide.

Most of you have seen this Venn diagram many times. It shows the three elements used in the assessment: technical feasibility of collecting and reporting measures, particularly in light of mandatory reporting beginning in 2024; desirability of measures, which relates to the actionability and strategic priority of the measures; and financial and operational viability which ties back to considerations like alignment across programs and state capacity for reporting. The goal for the Workgroup is to recommend measures that optimize these three elements. Next slide.

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

We also wanted to note that measure stewards typically update various aspects of the measure technical specifications each year. Changes can reflect a variety of factors such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users. Many of the measures being reviewed are in the process of being updated or were recently

updated. We have done our best to reflect the most accurate and up-to-date information about each measure. Next slide.

I'll wrap up this section with some additional context for this year's review. As you know, mandatory reporting of all Child Core Set measures and behavioral health measures on the Adult Core Set goes into effect in 2024. The Workgroup should review measures taking into account the three sets of elements in the Venn diagram shown earlier. Second, CMCS is continuing to explore the use of alternate data sources to support calculation and public reporting of current Core Set measures. The goals are to reduce state burden and improve the completeness, consistency, and transparency of measures. Core Set measures are currently being calculated on behalf of states using data from CDC WONDER and the NCI IDD Survey. Other data sources under consideration for the future are T-MSIS and the CAHPS Database. Last, there is an increasing emphasis on building state capacity to use digital measures and supplemental data sources for Core Set reporting. Next slide.

In each meeting, we always come back to our criteria for assessing measures. We know many of you have seen these slides several times before; however, we have some new Workgroup members and public attendees, and the criteria are foundational to the discussions over the next two days. The first category is our minimum technical feasibility requirements. All suggested measures must meet these requirements. So the measures we'll discuss today and tomorrow have passed through Mathematica's initial screen based on these criteria. This means that the measures should be fully developed and have detailed technical specifications for producing the measure at the state level; have been tested in or are in use by at least one Medicaid or CHIP program; have an available data source or validated survey that has an identifier for Medicaid and CHIP beneficiaries; and their specifications and data source allow for consistent calculations across states. CMCS also requires that the measure must include technical specifications, including code sets, that are provided free of charge for state use. However, Workgroup members do not need to consider this criterion. Next slide.

The second category is actionability and strategic priority. Measures that are recommended for addition to the Core Sets should contribute to estimating the overall national quality of health care in Medicaid and CHIP, and performing comparative analysis of disparities should address a strategic priority in improving health care delivery and outcomes and can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP. Next slide.

Finally, a few other criteria to consider; is the prevalence of the condition or outcome sufficient to produce reliable and meaningful results across states? Is the measure aligned with those used in other programs? Will all states be able to produce the measure within two years of the measure being added to the Core Set? Next slide.

When Workgroup members are considering measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. For example, we ask the Workgroup to consider; is the measure no longer making a significant contribution to estimating the overall national quality of care in Medicaid and CHIP? Are states unable to access the data needed to calculate the measure, or is the data source leading to inconsistencies across states? Is the measure unable to be used to assess improvements in state Medicaid and CHIP programs, or is there another measure that is better aligned with other programs? Of course this is not a comprehensive list of reasons for removal, but a few key considerations. Next slide.

Now with those criteria in mind, I'll provide an overview of the voting process. Voting will take place by measure after Workgroup discussion and public comment and will be for Workgroup members only. Federal liaisons and other attendees of today's meeting are not eligible to vote on measures. Workgroup members should let us know through the Slido Q&A function in WebEx if they will be absent for a portion of the voting. Remember, when you send us a question via the Slido Q&A feature, your question will say, waiting for review. Please click the word replies under your question to see our response. Each measure will be voted on as it's currently specified. If the measure is being considered for removal, a yes vote means "I recommend removing this measure from the Core Set." If the measure is being considered for addition, a yes vote means, "I recommend adding this measure to the Core Set." Measures will be recommended for removal or addition if two-thirds of eligible Workgroup members vote yes. Now I'll turn it back to Margo.

Margo Rosenbach:

Thanks, Caitlyn. Are there any questions from Workgroup members about the criteria or voting logistics before we practice voting? Remember to raise your hand, and I'll call on you. All right, well, it does not look like there are any questions from Workgroup members. So now I'll hand it back to Caitlyn and Talia to walk us through a practice vote. Caitlyn?

Caitlyn Newhard:

Thank you, Margo. As a reminder for all attendees, voting will be for Workgroup members only. Workgroup members, please navigate to the Slido voting page. You can follow this QR code, use the link listed in the Voting Guide, or go to Slido.com and enter 2026ChildAdultCSR as the event code. You'll be prompted to enter your email address and name, after which you will enter the verification code sent to your email. Be sure to use the same email address at which you received communications from the Mathematica Child and Adult Core Sets Review Team. You can remain on this page for the duration of the meeting, and new voting questions should appear as we make them available. If you don't see the new question, just refresh your page and it should pop up. If you need any help, please refer to the Voting Guide; or send us a chat through the Q&A feature in Slido. The third page of the Voting Guide has an FAQ section that answers most common problems. During voting on measures if for any reason you are unable to submit your vote, please send us your vote through Q&A in Slido or to our email address if you are not able to access WebEx. Your votes will be visible to the Mathematica team only.

Now let's go through a practice vote. All right, first vote: "Do you like coffee?" The options that should appear on your voting page are "Yes, I like coffee" or "No, I do not like coffee." If you aren't seeing the question, try refreshing your browser. All right, we'll give folks a few more seconds here. All right, voting is closed and the results are – all right, we'll give folks a few more seconds here to vote. It looks like we have not received all votes. All right, it looks like we are at 24 votes. If you want to, go ahead and message us via the Q&A in Slido if you're unable to vote and are a Workgroup member. Thanks for your patience, everyone. We're still helping a couple more folks get their vote in. Thanks again for your patience, everyone. The first practice vote always takes the longest; but we'll get these wrinkles ironed out, and that way it will be smooth sailing.

All right, it looks like we have nearly everyone. So we'll go ahead and close the votes and show results. It looks like 83% liked coffee. Next slide.

We have Practice Vote 2. The next vote is, “Are you a morning person?” The options that should appear on your voting page are “Yes, I am a morning person” or “No, I am not a morning person.” Again, if you’re not seeing the question, try refreshing your browser; and go ahead and submit your vote. All right, give folks a few more seconds here. Perfect, it looks like we are at 30 votes; so voting is closed. We’ll show the results. 70% are morning people.

Thank you for testing the voting. Like I said, it should get easier from here. Now we’ll be taking a break until 1:00 p.m. Eastern Time. If you have any questions about voting, feel free to reach out to us through the Q&A or mailbox during the break. We can help folks who were having any trouble voting, and we will return from break at 1:00 p.m. Thank you all.

BREAK

Margo Rosenbach:

Hi, everyone. I hope you enjoyed the long break. Welcome back. Now we’ll discuss the first measure suggested for removal: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD). I gather that we have a lot of folks who are interested in making public comments. Please hold your public comments until after the Workgroup discussion, and then raise your hand and we will call on you in turn. Also, I know CDC and PQA will also have some comments. So, please, also feel free to raise your hand when you’d like to make some comments. Now I’d like to turn it over to Maria to introduce the measure for discussion.

Maria Dobinick:

Thank you, Margo. Next slide.

The Use of Opioids at High Dosage in Persons Without Cancer, or OHD-AD, was suggested for removal from the Adult Core Set. The OHD-AD measure is included in the Care of Acute and Chronic Conditions domain. The measure is defined as the percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents, or MME, over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. The measure steward is the Pharmacy Quality Alliance, or PQA; and the data collection method is administrative.

This slide also includes the full denominator and numerator definitions for reference. The denominator includes beneficiaries who meet all the following criteria; two or more prescription claims for opioids medication on different dates of services and with a cumulative days’ supply of 15 or more days during the measurement year, an Index Prescription Start Date, or IPSD, on January 1 through October 3 of the measurement year, and an opioid episode of 90 or more days during the measurement year. Next slide.

The numerator definition is included on this slide. The numerator includes any beneficiary in the denominator with an average daily dosage greater than or equal to a 90 morphine milligram equivalent, or MME, during the opioid episode. The measure stratifications for Adult Core Set reporting are by age group, with the age groups defined as ages 18 to 64 and 65 and older.

This measure was reported by 40 states for FFY 2022 Core Set reporting with six of those states calculating the measure using other specifications; specifically, the HEDIS specifications for Use of Opioids at High Dosage. Note that the states using other specifications are excluded from public reporting. This measure is included on the Medicaid and CHIP Scorecard. A

Workgroup member suggested this measure for removal due to concerns about the measure's actionability and strategic priority. The Workgroup member acknowledged that while the measure has been discussed by the Workgroup several times in the past, it merits discussion again because of the lack of alignment with federal policy, strategy, and goals. For example, the Workgroup member commented that the measure conflicts with Goal 3 of the CMS Behavioral Health Strategy, which is to ensure effective pain treatment and management. The Workgroup member further stated that a standardized population-level measure on prescription opioid dosages does not capture the individualized nuance that evidence-based pain care necessitates and leaves out the patient care and safety concerns that are cited in the CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain. The Workgroup member indicated that CDC's 2022 clinical guidelines cautioned against the implementation of dosage limits, such as those set out in the OHD-AD measure, and emphasized the importance of flexibility in meeting the care needs and clinical circumstance of each patient. They suggested that inclusion of this measure in the Core Set would result in inconsistent messaging among HHS operating divisions regarding the use of opioids to treat patients living with pain. The Workgroup member further commented that OHD-AD may incentivize rapid dosage reduction and called for greater nuance in addressing the harms of high opioid dosages. They pointed out that once patients are on high dosages, there are associated harms with both remaining on and reducing those high dosages. Finally, the Workgroup member highlighted alternative efforts by the CDC to mitigate and assess the harms of high opioid dosages; for example, by developing new clinician education and communication materials and engaging with professional organizations to support implementation. They suggested that CMS may wish to partner with CDC on this work in the future.

The measure steward, Pharmacy Quality Alliance, commented that instances of unintended consequences associated with the measure have not been observed. They also noted that the OHD measure specifications explicitly state that it is not intended as a rigid or inflexible standard of care. Next slide.

Now I'll pass it back to Margo to facilitate the Workgroup discussion.

Margo Rosenbach:

Thank you, Maria, for that overview of the measure. So, with that, if you have a comment, please raise your hand; and I will call on you in turn. The first person I see is Deborah Dowell.

Just a reminder that if you are a member of the public, please lower your hand now; and I will call on you when public comment begins. Thank you.

Deborah Dowell, you are up. Please say your full name, where you're from, and provide your comment. Thank you.

Deborah Dowell:

Hello, this is Deborah Dowell. Can you hear me?

Margo Rosenbach:

Yes, very well, thank you.

Deborah Dowell:

Okay, great. I am the Chief Clinical Research Officer for the Division of Overdose Prevention at CDC, and I wanted to clarify that CDC is the Workgroup member that has recommended this measure for – or suggested this measure for removal. I wanted to note that CDC has serious concerns about maintaining this measure in its current form, and we urge the Workgroup to revisit this discussion. We believe the inclusion of this measure carries a risk of patient harm, that this measure is in direct conflict with the 2022 CDC opioid guideline and its intent. Its inclusion in the Core Set does not incentivize patient-centered behavior and could disrupt the important relationship between a clinician and patient.

We acknowledge that during prior discussions of this measure and its removal, there have been concerns about leaving a gap in the opioid prescribing space. But in the spirit of "first, do no harm", the risk this measure presents to patient care is sufficient in and of itself to justify removal. We can and should work together to fill any gap quickly, and we have some ideas to offer; but we shouldn't risk additional harm to patients in the interim. I'm happy to expand on any of this or answer other questions if that would be helpful.

Margo Rosenbach:

Thank you so much, Deborah. I see that Lindsay is up next.

Lindsay Cogan:

Great, thank you. Thank you for your comments. I really appreciate this measure being brought up again. I agree with everything that CDC said. I also had some concerns about the MME really being – that being brought up to sort of a population-level measure. I think often when you're looking at prescribing at sort of that individual clinician/patient level, sometimes what gets lost in translation is those person-centered or decision-making skills, right? So, we've done a lot of structural interventions around safe prescribing of opioids; and we all know it's still an issue, right? So, since 2019 and as a part of the SUPPORT Act, there's been a lot of implementation of really excellent activities across the states, including prior authorization, looking at different ways to utilize our prescription drug monitoring program. So, there's a lot of effort, and it's not to say that to vote a measure off means that we don't think it's important. But I would also really love to hear from the CDC, who I really see as a leader in this, in thinking about a measure of prescribing – overall prescribing. I see in their dashboards they are monitoring state overall dispensing rates of opioids using IQVIA. As I understand it, that is something that could be stratified by payer. You could then have a monitoring measure in place that would, I think, help to elucidate all of the hard work that we as states are putting into safe prescribing efforts but at the same time reduce burden across states in reporting a very computationally difficult measure to report.

Margo Rosenbach:

Thanks, Lindsay. Deborah, did you want to respond on behalf of CDC to Lindsay's comments? Deborah, I see – yes, you may unmute.

Deborah Dowell:

Sorry, I was having trouble unmuting myself. Yes, I appreciate and agree with Lindsay's comments. We agree that it's very important to have measures in this area, and we agree that some measure on general prescribing would be less likely to cause harm. We have some specific thoughts on measures to propose, as well as measures that are being used elsewhere. I don't know if this is the time to get into those; but for example, a measure on initiation of

opioids for headache or fibromyalgia where we know that opioids may be likely to cause harm, we think would be less likely to be harmful than this specific measure. It also gets at initiation of opioids, which is where we really think we need to do the preventive work. While opioids should be started at the lowest effective dose and should rarely be increased, reducing dosages in patients already receiving high dosages long term requires substantial care to avoid harm. We are concerned that this particular measure incentivizes clinicians to rapidly reduce patients who are already on high dosages and may be at very high risk potentially from continuing opioids at high dosages but also from rapid reduction or any reduction. Their care needs to be carefully managed, and we're concerned that this measure will incentivize people – and we've heard reports that this is actually happening -- may drop people from care and may not accept new patients in this category for new care when these are patients who really need attentive care and careful consideration of their medications.

Margo Rosenbach:

Thanks, Deborah. Next up is PQA, Ben Shirley, the measure steward. Ben, can you unmute and speak? You look like you're muted again.

Derek, can you unmute Ben Shirley, please? You should be unmuted now.

Ben Shirley:

Can you hear me?

Margo Rosenbach:

Now I can, thank you.

Ben Shirley:

Okay, great, sorry about that. I really appreciate the discussion here today. I think we certainly agree and fully understand the backlash that we saw when it came to the 2016 CDC guidelines, and I think the misapplication of those guidelines in terms of hard edits and removing folks from care. I think we agree with everyone on here that hard edits or hard limitations on access to pain treatment is totally incongruous with what we are trying to do here from a quality perspective. I do think just looking at this conversation, and we're talking about measures in a program context, right? The Medicaid Adult Core Set is a public reporting and benchmarking program intended to help states understand, in this case, maybe the rates of folks on very, very high-dose opioids and understand where they are and the need to potentially look at quality improvement. It is, I think, a strong mischaracterization both of the OHD measure and the Core Set, I think, as a population-level program to suggest it as applying inflexible standards to individual patients and providers.

Correct me if I'm wrong, Core Set folks, but it's intended to be benchmarking to inform and empower states to make comparisons. I'd be remiss if I didn't speak to performance here. This is the only place where we can currently see differences in state-level Medicaid quality; and with respect to this measure in opioid use, they're very substantial. We have folks at two, three times the median rate here; and our ability to see that will go away if this is removed, right? I think from our team's perspective, it is information that the states should be empowered with. I think we struggle with the removal of this information. I know there's a lot we could speak to. That being said, I do want to also state I certainly agree on behalf of our team on this interest in the initiation piece and more upstream intervention. That's something that PQA has invested a lot of

time and effort in. We do have an initial opioid prescribing measure specifically for – excuse me – long duration that's used in various ways in Part D. That's certainly something that the Medicaid Core Set could look at aligning for. But I was, again, looking at the statistics before jumping on this call; and I think that the most recent CDC data is 47 prescription opioid deaths per day. So, I think that we really struggle -- as we've discussed, I think this is our fourth time – with that gap. So, trying to both acknowledge this importance while also provide some other alternatives potentially as well.

Margo Rosenbach:

Thanks, Ben. So we have a lot of people lined up. So, David Kelley, you're next.

David Kelley:

Thanks so much and appreciate the previous comments. I think that, at least in Pennsylvania, we have historically worked with our managed care plans and with our program to really make sure that there's no harm done in looking at this particular quality measure. So, we've been very careful to make sure that our MCOs are working with their provider networks to assure that folks have ongoing access to opioids even if they are on very high doses. With that being said, I think there are other tools in the toolbox at this point. We rely on our PDMP at the state level to continue to report this. I'd say over the last five years, we've seen a pretty big decrease in overall opioid prescribing and especially higher-dose opioid prescribing. We do report – I believe there's a similar HEDIS measure; and we report on that, which is a good tool in the toolbox. We've seen our trends come down in the last two or three years. I think we're down to like 7.5% of individuals. So, I think there are other tools in the toolbox at this point. I know that - I think the CDC has a resource. They used to provide a chart and a table for what equals 90 MMEs, and I don't know if that resource is still available. But as a state, we can still fall back on kind of the HEDIS measure. So, if this does come off or is voted off, we'll continue to probably look at it from an NCQA standpoint. And again, I always look at ways to harmonize so that our managed care plans within the Medicaid program are not having to dual report, and we as a state don't have to dual report. Thanks so much, and really appreciate the sensitivity and the fact that we do need to think in terms of being patient-specific in our quality of care and safety concerns. Thanks.

Margo Rosenbach:

Thanks, David. I'll just mention, as I think Maria did, that a number of states, like Pennsylvania, do not use the Core Set specifications and are not included in public reporting. So that's just another thing to note. Next up, David Kroll.

David Kroll:

Thanks, everyone, for their comments. I agree that this is a very difficult area to measure quality and that there are – it's a very hot-button issue as well because on the one hand we're dealing with a pretty serious problem, which is the opioid epidemic and all the risk associated with opioid use. On the other, there are cases where this really does seem to be the only way to really get pain under control. I want to comment that I actually don't think that the quality measure in and of itself is the leading reason why clinicians are often sort of afraid to take on patients who are on high-dose opioids. There's actually quite a lot of variation in terms of prescriber attitudes towards opioids and what's an acceptable threshold – how much is too much, how much is high risk? I do think that one of the things this quality measure does

accomplish is send a very clear message that medical consensus is that quality measures really – quality care really does push prescribers away from high-dose opioids and other ways of managing chronic pain. I worry a little bit that if this measure is taken off without something equally strong to send that message, that really does weaken the message that I think mainstream medicine is really trying to communicate across practitioners – that this is a really important area and that potentially unchecked high-dose prescribing is something that's really considered outside of the mainstream.

I also want to say that this measure does not prohibit prescribing higher doses to individual patients. What it does is really set the tone for across-the-patient population, this is how we're defining quality care. Moreover, if we think about how patients get on these high doses, in non-cancer cases, I would actually argue that this measure is as much of an outcome measure as it is a process measure because the reason that people end up on high doses is because they're on opioids for prolonged periods of time. They're liable to develop something called opioid-induced hyperalgesia. What opioid-induced hyperalgesia refers to is a condition in which patients who are chronically exposed to opioids over time develop higher and higher levels of pain on their own so that when you take away the opioids, the baseline pain is actually higher; and you need higher doses of opioids to now control that pain. So, when we see people on these really astronomical doses of opioids, it's often after many years or even decades of gradually escalating doses of opioids; and it's often a signal that treatment in sort of mainstream ways and safer ways has really failed, right? It means that they have not really been able to benefit from non-medical interventions like physical therapy. They've not been able to benefit from other strategies that are often more sustainable and safe. So, we see these patients often at the end of a treatment course on these high-dose opioids, and it's really not a signal – okay, now their current prescriber is necessarily prescribing bad care. But rather, this is now an endpoint where we've actually seen a poor outcome for this patient who came in with chronic pain that in many cases actually could have been managed more effectively. So, I would urge this group to really think about this more as an outcome measure as well as a process measure and really understand that this is something that I do think is a very important indicator of quality care still. Thanks.

Margo Rosenbach:

Thank you, David. Lisa Patton, you're next.

And just a reminder also, Workgroup members, if you have questions, please raise your hand ask them verbally rather than through the Q&A – appreciate that. So Lisa, you're next.

Lisa Patton:

Thanks, Margo. I don't disagree with the comments from CDC, and I think that I'm more in alignment with PQA's characterization of where we are with this measure. I have tracked this measure since it was first developed by PQA at 120 MMEs and then reduced to fit the 2016 CDC guidelines. Really, I'll be short because David Kroll said a lot of what I had wanted to share with the group. My concern is just that I'd prefer that we look at chronic pain management, that we look at alternative pain strategies. And kudos to CMS and the states for their work around alternative pain strategies, as well as work on reducing those outlier high prescribers and really getting us to where we are now. But this remains an ongoing issue. It remains an ongoing problem; and because we don't have those new measures in place yet, I'm really leaning toward keeping this one for now having seen the evolution of the measure over time and its use and the concomitant efforts by a variety of federal agencies – CDC, SAMHSA, HRSA, and CMS. I think

we're really driving toward better care here, but I would really like to see some new measures be available that we could then bring to bear on these issues.

Margo Rosenbach:

Thanks, Lisa. Rich Antonelli, you're next. Then, Deborah, we'll turn back to you from CDC. Rich?

Rich Antonelli:

Yes, thank you. I so appreciate this conversation. I'm having a little bit of a déjà vu all over again. We struggled with an asthma measure in this group a couple years ago and recognized there's nothing better to replace it with, so how could we pull it back? So, I would commend our colleagues in the Commonwealth of Pennsylvania for finding other approaches to this. But the way I look at this measure is actually kind of aligned with what Dr. Kroll said. It is a high-level indicator. I'd feel so much better about supporting removal if there was something imminently ready to go. The optics of that, I think, are critically important. So, if it's possible for our CDC colleague to give us some specifics of the types of harm that you are aware of, that will help inform my voting decision. Thank you.

Margo Rosenbach:

Thanks, Rich. Deborah, you're next.

Deborah Dowell:

Yes, first just to respond to that last question, we know according to multiple reports that rapid reductions that put patients at risk are occurring in order to lower dosages below 90 MME. In 2019, a consensus panel published a report that inflexible application of dosage thresholds encouraging hard limits and abrupt tapering -- and I appreciate PQA's earlier comments that these are not hard limits, but we understand that they can be perceived as such by clinicians -- are resulting in sudden opioid discontinuation or dismissal of patients from a patient's practice. The panel also observed that some clinicians, policymakers, managed care administrators, and pharmacy benefit managers have inferred an enforceable 90 MME dose ceiling as a de facto mandate. Panelists also described patients who request providers to assume responsibility for opioid prescribing after involuntary dismissal from another practice without weaning or a plan to treat their pain or opioid use disorder. In addition, CDC received many public comments during development of the 2022 clinical practice guideline emphasizing that abrupt opioid tapers, sudden discontinuations, and patient dismissals are occurring. Because of these reports, both CDC and FDA have issued warnings against rapid opioid discontinuation.

I wanted to recognize some of David Kroll's important points about the messages we're sending as well, but I think there's many different ways we can do this. As the speaker from Pennsylvania noted before, we have lots of tools in our toolbox at this point. I think that a general opioid-prescribing measure could do more to get at this problem with less harm. The recent speaker talked about how this is an indicator of poor care, and I don't disagree with that; but I would argue that it's a lagging indicator. This happens after quite some time of patients, one, initially being started on opioids when opioids might not have been the best option in the first place and then continued dosage increases. Those are the things we want to prevent and make sure that we get out the message that pain care is quality care, which we don't think that this measure sends that message. We feel that we've seen lots of evidence that even if we put asterisks and say this is not a hard stop, we believe we have lots of evidence now that this is

being interpreted as a hard stop; and it is harming patients who are losing access to their providers, having trouble getting access to new providers, going into withdrawal. This is especially a concern in the atmosphere of an opioid epidemic that is now being driven by illicit drugs. I just want to reiterate that we think we have other options and that we're happy to lead a coalition to come up with a measure that will send the messages we want to send without keeping this measure in place. We know similar messages to this measure that are out there are causing harm now.

Margo Rosenbach:

Thanks, Deborah. We have a number of people lined up who want to speak from the Workgroup. So with that, maybe next up – Ben Anderson.

Ben Anderson:

Yeah, hi, thank you, good afternoon. Good morning to folks on the West Coast. I'm, I think, still a little uncertain based on the comments that have been raised about what might be appropriate in this case. It does sound like some of the information yielded from this measure can be potentially insightful at times; however, I do think it's alarming to hear what kinds of incentives this measure has created in certain clinical contexts because of confusion. I do wonder in light of the fact that there are other tools, there are other measures, that might be more useful in this space – I wonder if we could think about what exactly is the problem that we're trying to solve with the measure, and is this measure the appropriate tool or the one that we would pick? If it's not, I do wonder if that means we should in fact remove it from the Core Set. I'll stop there and look forward to hearing other discussion.

Margo Rosenbach:

Thanks, Ben. Ben Shirley, you're next. Are you able to speak? Why don't we move on to David Kroll?

Ben Shirley:

Hi, everyone, can you hear me?

Margo Rosenbach:

Yes.

Ben Shirley:

Yeah, sorry, I think I have to wait to be unmuted by the host. But you can hear me now?

Margo Rosenbach:

Yes, we can.

Ben Shirley:

Perfect, thanks so much. Yeah, completely agree – I think that this is a great discussion. I think just some responses or thoughts – I think that of course everything that's been mentioned by the CDC certainly stuck out to PQA as we reviewed the guidelines. I think that misapplication of these guidelines and the sorts of hard edits and rapid tapers that are being discussed that are

put in place by plans or by other types of payers – the fact that that's happened in the past in different settings, in different contexts, I think our team would argue that that shouldn't prevent any measurement from taking place at all. Again, I think our team sort of fears we're throwing out the baby with the bath water because in different settings, different program contexts, often with dollars on the line and those contracts potentially, if in that context unintended consequences have been observed, should that limit sort of measurement in any other context, even in programs where there's not really an a priori mechanism for those to happen?

PQA, in the context of this program where it's been for a long time, has not seen those reports. Many CMS programs are pay-for-performance when we look at the culprits for rapid tapers. I think you're going to be seeing contracts where providers are financially, or were financially, penalized. The Core Set is not one of those programs. Again, I think our team is a little concerned about applying complaints from a very different program to another program and sort of talking about the measure as a monolith as opposed to the measure as something that can be used in different programs in valuable ways. I'll give up the floor. But with that being said, I do think there is some middle ground. I know that folks were asking about a replacement. Again, there is an opioid initiation measure of long duration that PQA has developed. It's consensus-based, endorsed NQF/Battelle. It's in Part D monitoring program. So, there is sort of another option; but I think our team would also echo for those who've been with the Core Set for a while, we can take something out but it's hard to have a guarantee if and when something will come back in. So it's a bit uncertain from that perspective, right? We've all been through these meetings. So, I'll pass it on.

Margo Rosenbach:

Thank you. If you could wrap up, we're running well behind time and other people in line. Do you have any other wrap-up comments, Ben?

Ben Shirley:

Nope, I do not.

Margo Rosenbach:

Okay, so I'm going to start calling on people who have not spoken before and then turn to public comment. So next up, Ellen Blackwell. Please introduce yourself.

Ellen Blackwell:

Can you hear me?

Margo Rosenbach:

You are very faint, but...

Ellen Blackwell:

Okay, all right, I'll try to raise my voice a little bit.

Margo Rosenbach:

That's great.

Ellen Blackwell:

I am in CMS's Center for Clinical Standards and Quality. I work on behavioral health issues, including our behavioral health strategy which my CDC colleague, Dr. Dowell, mentioned in her opening remarks. I just wanted to indicate that we support the comments that our CDC partners have made and also flag for the group that last year, in addition to a focus on pain management in our behavioral health strategy, we introduced new payment codes into the Medicare program that really focus on the holistic treatment. I know one of the other group members mentioned the toolbox, and that is really the approach that we hope to be seeing in the future. Perhaps as measure development matures, things may indeed go that way. But this particular code really is quite interesting and has many elements; like for example, the development of a person-centered care plan, treatment management, diagnosis, medication management, pain and health literacy counseling, crisis care, connections to other providers. So, I think if you look at aside from just one particular medication and think more in a roundabout way about pain management, that might help the group focus just a bit. I'm happy to send the link to the final regulation on the pain codes to the contractors so that you can take a look. There were also some slides on these codes presented at the Interagency Pain Federal Research meeting back in June or July, and we are very excited about taking this particular approach to pain.

Margo Rosenbach:

Thank you so much. Last person on the Workgroup to speak is Jeff Huebner. You have the floor.

Jeff Huebner:

Hi, everyone, thanks. I'm a practicing family physician and first time in the Workgroup, so appreciate all the work that's gone into this. I'm also serving currently as our CMO of our state Medicaid program. I've been involved in working with patients with chronic pain throughout my career and also involved in a lot of QI efforts at the health system level and now with Medicaid. Really appreciate the direction of the conversation, and it's wonderful to know how CDC and CMS are thinking about this. I agree that it's really important to have alignment in our messaging and what we're working towards. I'm excited about the future measures that are in development. I think ideally it would be wonderful to have a measure that would replace if we remove, but I also understand and have seen the consequences of the focus on reduction of morphine equivalent in my own practice setting and in QI efforts in other practices. So I do support removal, and I'm hopeful that we will come up with another measure as soon as we can. Thank you.

Margo Rosenbach:

Thank you for those comments. And with that, we will open it up for public comment. I see Kate Nicholson.

Kate Nicholson:

Hi, everyone. Thank you for the opportunity to speak today. My name is Kate Nicholson. I'm the Executive Director of the National Pain Advocacy Center, or NPAC; and I was also, for disclosure, a member of the CDC's opioid workgroup. NPAC supports the removal of this metric. Whatever its intended use, in practice these sorts of metrics have become the kind of strict application of the CDC's 2016 guideline that the guideline authors, including Dr. Dowell, rejected in 2019 in their New England Journal of Medicine article, "No Shortcuts to Safer

Prescribing," due to risks of patient harm and that the 2022 update rejects, favoring discretion over one-size-fits-all mandates. NQCA was warned about the potential danger to patients with the adoption of strict metrics, in particular that widespread unilateral dose reduction would be incentivized, in a letter signed by 80 addiction, pain, and opioid experts; and we now have nearly a dozen studies showing harms from this sort of tapering, including increasing the risks of overdose and suicide by three to five times. I'd be happy to paste those studies into the Q&A if members want more evidence.

Just a note from the field, NPAC continues to hear from people all over the country who are being rapidly tapered and abandoned in care. Just to put it in human terms, I want to tell you a brief story. NPAC recently supported a new law in Colorado to protect against these harms. One of our key testifiers was a 59-year-old Latino man named Kenny Mastis, who has quadriplegia. When he was stable on pain medication, he was able to work full time, raise his son as a single father, and contribute to his rural Colorado community. But when his medication, which was slightly over the 90 MME metric, was stopped suddenly by his provider, his health rapidly deteriorated. His breathing became extremely belabored, and luckily his son called 911. But still at the hospital, Kenny flatlined. He woke up on a ventilator, which is not really quality care. In sum, lumping everyone with chronic pain regardless of the severity of their underlying condition or disability, how they metabolize opioids given known genetic polymorphisms, and their health needs and preferences into a single category and dictating a ceiling dose has done tremendous harm. So, we strongly urge a vote to remove. Thank you so much.

Margo Rosenbach:

Thank you, Kate. Stefan Kertesz, please introduce yourself. Derek, could you please –

There you go. You're unmuted.

Stefan Kertesz:

Hello, I am Dr. Stefan Kertesz. I am Professor of Medicine at University of Alabama in Birmingham; and I serve on my VA hospital's Opioid Risk Mitigation Team using the strategy that's been proven to save lives in published randomized trials. I would affirm that removal of the high-dose opioid measure is justified; and in fact, from 2017 on, safety concerns should have prevented it from being adopted. Any metric that identifies an opioid dose level as bad creates compelling incentives on health plans, Medicaid offices -- including my own state, law enforcement, and doctors. Clinicians are incentivized or forced – and I've seen it – to taper all patients above that dose. Yet, across-the-board, taper was not endorsed by the CDC's guidelines of 2016 or 2022. Historically, this dose-based measure was proposed by PQA and endorsed by National Committee for Quality Assurance in 2017; but I actually led the group letter to NCQA to caution against that step. That letter was signed by four experts who had helped produce the 2016 CDC guideline, including Dr. Erin Krebs and 76 others. The letter said that the metric would cause safety problems by inducing dose reductions without individualization, an untested medical intervention. I also briefed NCQA's Vice President. I told her that new Veterans Administration analyses showed that opioid stoppages, sudden or not, were associated with increased death by suicide and by overdose. NCQA did adopt the quality metric, as did CMS. I then arranged for the Food and Drug Administration to receive a briefing on the VA data, and the Food and Drug Administration issued a public warning on the risk of death by suicide. We should be concerned when there is such a striking divergence between quality measures and patient safety.

To date, there have been about a dozen papers, all academic, correlating dose reductions with death or destabilization; and, to correct the record, not just rapid reductions. Papers show the same with non-rapid reductions in Oregon's Medicaid and in Medicare, published in JAMA. I will add that the scientific risk measurement system used in the VA, dose counts as a risk factor, but it's actually one of the weaker indicators of risk and can be misleading. I am not saying that suicide or overdose are merely explained by how we change doses, downward or upward. Life is complicated; patients are too. What I am saying is that the incentivized across-the-board dose reductions have happened as a policy as a result of the metric with harmful outcomes. As Dr. Dowell has said, the CDC repudiated that practice. Removing this metric could help us begin to correct an ongoing harm to patient safety.

Margo Rosenbach:

Thank you so much for those comments. With that, I am not seeing any further public comment; so I think at this point, we will close out the discussion. Thank you, everybody, for such a robust discussion. Now I will turn it over for voting.

Alli Steiner:

All right, thank you, Margo. We are going to get the vote pulled up on the slide here, okay. So, for our first vote, should the Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) measure be removed from the Adult Core Set? The options are yes, I recommend removing this measure, or no, I do not recommend removing this measure from the Adult Core Set. The voting is open. If the question does not appear, please refresh your browser.

All right, thanks, everyone. We're just going to wait for a few additional votes to come in. Thanks for your patience. We're just checking on the votes and trying to figure out if we're missing any votes. Thanks. All right, everyone, let's close the vote.

Okay, so for the results, 79% of Workgroup members voted, yes. That does meet the threshold for recommendation. The Use of Opioids at High Dosage in Persons Without Cancer measure is recommended by the Workgroup for removal from the 2026 Core Sets.

Okay, and I'm going to pass it now to Maria to talk about the next measure.

Maria Dobinick:

Thank you, Alli. Next slide, please. The Initiation and Engagement of Substance Use Disorder Treatment, or IET-AD, measure was suggested for removal from the Adult Core Set. This measure is included in the Behavioral Health Care domain and is included in mandatory reporting beginning in 2024. This measure is defined as the percentage of new substance use disorder episodes that result in treatment initiation and engagement. Two rates are reported; initiation of SUD treatment is defined as the percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. The second rate is engagement of SUD treatment, which is the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. The measure steward is the National Committee for Quality Assurance, or NCQA; and the data collection method is administrative or electronic health records. This slide and the next include the full denominator and numerator definitions for reference.

The denominator is the number of new substance use disorder episodes for beneficiaries age 18 and older as of the SUD episode date. There are two numerators. Numerator 1 is the initiation of SUD treatment. Next slide.

Numerator 2 is illustrated on this slide and is the engagement of SUD treatment.

For the purposes of Core Set reporting, states calculate and report each of the rates for two age groups: ages 18 to 64 and age 65 and older. For each numerator, states also report SUD diagnosis cohorts for each age group; alcohol use disorder, opioid use disorder, other substance use disorder, and total. This means that for each numerator, data are stratified by two age groups. Within those two age groups, four diagnostic cohorts are also reported. This equals a total of 8 measure rates per numerator and 16 total for the measure. In addition to the stratifications just detailed, beginning with FFY 2025 Adult Core Set reporting, states will be required to stratify the two total SUD rates by three separate categories using established data standards as follows: race and ethnicity using the disaggregation of the 1997 Office of Management and Budget minimum rates and ethnicity categories, as specified in the 2011 HHS standards; sex, defined as biologic sex used in the 2011 HHS standards; and geography using a minimum standard of core-based statistical area with recommendation to move toward Rural/Urban Commuting Area codes. The HEDIS measure year 2024 specification for this measure requires stratification by race and ethnicity. NCQA indicated that they have not assessed the feasibility of stratifying this measure by additional factors such as sex, rural/urban status, disability, or language. Next slide.

Finally, the measure was reported by 46 states for FFY 2022 Core Set reporting. It should be noted, however, that the threshold for public reporting was only met for the 18 to 64 age group and that some states did not report all measure rates for this group. This measure is included on the Medicaid and CHIP Scorecard. A Workgroup member suggested this measure for removal because the measure changed from an individual-based measure to an event-based measure for HEDIS measurement year 2022, which corresponds with the 2023 Adult Core Set. The Workgroup member acknowledged that while the measure has been discussed in the past, it merits discussion again because there's now an overlap with similar measures on the Adult Core Set; for example, Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD) and Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD). The Workgroup member suggests that there is not a need for similar measures looking at care in a slightly different way. We also wanted to note that in addition to the change to an event-based measure, NCQA made several other changes to the technical specifications that went into effect for the 2023 Adult Core Set. They changed the denominator to lengthen the negative SUD history period from 60 days to 194 days and removed ED visits and medically managed withdrawal from the negative SUD history period. The removed the numerator requirement that psychosocial treatment accompany pharmacotherapy, and they revised the age stratifications. All state performance data shown in the Measure Information Sheet and in the FY 2022 Chart Pack refer to the previous version of the IET-AD measure. Next slide.

Now I will pass it back to Margo to facilitate the Workgroup discussion.

Margo Rosenbach:

Thank you, Maria. Now we'll invite discussion about the IET measure from Workgroup members. Please raise your hand if you wish to speak. I'll call your name, and we'll unmute you when it's your turn. Do we have any Workgroup members who want to speak about this measure? Lindsay Cogan?

Lindsay Cogan:

Thanks, Margo. I have brought this up before. It's just kind of one of those sort of core quality measurement principles not to have measures that measure the same thing in a slightly different way. It becomes a real issue when you're trying to sort of message and combine sort of actionability pieces. This measure rolls up a lot of different components all into one. The inpatient/outpatient medication-assisted therapy, ED visits – sort of that all goes into this one rate. I do like that this measure is stratified by different diagnosis cohorts. That has added a new dimension that I think is helpful, but having everything rolled up into one big number makes it really hard to tease apart and then provide sort of that meaningful directionality to plans, providers, other stakeholders really looking to work within this space and make a difference in this particular condition. So, I think it does merit the opportunity to think about do we need, in an era where we are really trying to provide actionable information, have measures that measure the same thing in a slightly different way? As we get into this mandatory reporting, every time we stretch ourselves a little bit thinner and thinner, there's less resources to really act on all of this. So that is where I landed with this particular measure.

Margo Rosenbach:

Thanks, Lindsay. Other Workgroup members? David Kelley.

David Kelley:

Yes, thank you so much. Here in Pennsylvania, we've used this measure; and we're a carve-out state, so we have to work extra hard to get our results here between physical health and behavioral health. But we actually use it as an incentive between our physical and behavioral health plans to actually look at what's happening across the continuum of all levels of care of substance use disorder treatment. So, we think that this is really a quite valuable tool. If you look at the performance, there's lots of room for improvement. I'm a little puzzled. Some of the other measures looking at follow up after emergency department for substance use – that's just one subset. This is a broader look at what's actually happening to your population as a state, and each of our MCOs look at this as well. Now, yes, there have been a lot of changes that I believe NCQA has made. I think that those changes for the most part I think are for the better, but I see this as a really valuable quality improvement tool that's actually quite actionable. We actually measure it down to the county level. So, I would be concerned if we removed it from the Core Sets. I still think that there's a lot of value. I don't know if we want to go back and look at what are the actual results for this measure, but I think there's a lot of room for improvement in both the initiation and engagement. Thank you.

Margo Rosenbach:

Thanks, David. Other Workgroup members? Ben Anderson.

Ben Anderson:

Yes, hi, again. I share, I think, the same sentiment as David with respect to this measure. I think what's striking to me about it is we know all of the different ways that people can show up in different places within the health care system, exhibiting sort of the need for initiation of these services. While there may be some overlap with some of the other measures that are out there, if we were to potentially look at removing a measure, I don't know that this would be the one but am open to, of course, hearing more about that. But I think at this point in time, this measure is one that sounds like it ought to stay put.

Margo Rosenbach:

Thanks, Ben. Other Workgroup members? Kim Elliott.

Kim Elliott:

Sorry, I hit the mute twice. I like this measure because it does something that some of the other measures in the Core Sets don't do, which is you identify the issue. You then have an opportunity to do some real care management or case management and follow the member to make sure they get engaged in treatment. We don't have a lot of other measures, particularly with these challenging type of conditions, where we have that type of measure set. So, I like this measure, and I think it does provide extra opportunities for both the managed care organizations and the state to really wrap some resources around to make sure people get engaged in care.

Margo Rosenbach:

Thanks, Kim. Other Workgroup members? Lisa Satterfield.

Lisa Satterfield:

Hi, can you hear me?

Margo Rosenbach:

Yes.

Lisa Satterfield:

Okay, good. Yeah, I want to echo my colleagues' comments. My only concern would be if this becomes a mandatory measure, how difficult is it to gather the information? I see that it's not widely adopted, but it is reported by several states. So, is it really difficult to get this kind of information to report back? I guess that would be my question for anybody who has this experience – David, maybe you.

Margo Rosenbach:

Well, I could jump in real quick, Lisa, and respond to a couple things that have been mentioned. One is the measure was reported by 46 states, so almost all states have begun to report the measure. But the other thing, we did go back and check the state medians for the measure. I think somebody had asked for performance on the measure and room for improvement. I'll just mention that across those states for FFY 2022, the state median was 43.4% for initiation and 15.8% for engagement – so clearly a lot of room for improvement in terms of timely follow-up. Hopefully, that provides a little more information about both the level of reporting and the level of performance. David, did you want to add anything from your state's experience?

David Kelley:

Thanks, I just got unmuted. The only thing that I would add is that from a feasibility standpoint, this is primarily claims-based. So probably one of the challenges – and I mentioned we're a carve-out state, where we get our encounters from both our physical and our behavioral health plans – so that is a little bit of a challenge. I'd say we're probably in the minority as a carve-out state, but that would be the only feasibility challenge. Then probably the other consideration is

whether or not all state Medicaid programs cover the full ACM level of care, but that's probably not as significant in looking at the comparability. But thanks, Margo. I think I had actually asked about the performance on both the initiation and engagement; and there really is a lot of room for improvement. Thanks.

Margo Rosenbach:

Thanks, David. Other Workgroup members? Last call before we open it up for public comment.

Okay, with that I will open it up for public comment. If you have a comment about this measure, please raise your hand and I'll call on you. Last call on public comment before we turn to the vote.

All right, well, I don't see any more Workgroup members or public comment. So, let's turn to the vote. Alli and Talia, thank you.

Alli Steiner:

All right, thanks, Margo. I'll get the vote pulled up. All right, so for the second vote, should the Initiation and Engagement of Substance Use Disorder Treatment measure be removed from the Adult Core Set? The options are yes, I recommend removing this measure from the Adult Core Set, and no, I do not recommend removing this measure from the Adult Core Set. Voting is open. As a reminder, if the question doesn't appear on your page, please refresh your browser. All right, we can close the vote.

Okay, for the results -- 85% of Workgroup members voted, no, I do not recommend removing this measure from the Adult Core Set. So this measure is not recommended by the Workgroup for removal from the 2026 Core Set.

Margo Rosenbach:

All right, thank you so much, Alli and Talia. Thank you, everyone, for being so efficient with the voting. That worked out really well. Is there any further reflection on this measure before we move on to the next break? Okay, well with that, actually we will return from the break at 2:45 p.m. I hope everyone enjoys time to stretch your legs, read some email, and then please do come back after the break for the next measure, which is Prenatal Depression Screening and Follow-Up. Thank you.

BREAK

Margo Rosenbach:

Hi, everyone. Welcome back from the break. Now we'll talk about our third measure of the day, Prenatal Depression Screening and Follow-Up measure. I'll turn it over to Caitlyn Newhard to lead the discussion.

Caitlyn Newhard:

Thanks, Margo. Next slide. Now we will discuss the first measure suggested for addition to the 2026 Core Sets, Prenatal Depression Screening and Follow-Up. The measure is defined as the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported; depression screening – the percentage of deliveries in which members were screened for clinical depression during

pregnancy using a standardized instrument and follow-up on positive screen – the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding. National Committee for Quality Assurance, NCQA, is the measure steward; and the measure is specified at the health plan level. The data collection method is HEDIS Electronic Clinical Data Systems, or ECDS. ECDS includes data from administrative claims, EHRs, case management systems, health information exchanges, and clinical registries. Given this is a new measure, we wanted to spend a few minutes discussing the specifications.

The measure includes denominators for two rates: first, depression screening – deliveries during the measurement period, January 1st to December 31st, that meet the following criteria; meet requirements for participation. Participation is defined as the identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Participation includes both allocation and continuous enrollment criteria. The allocation criterion requires the member to be enrolled with a medical benefit 28 days prior to the delivery date through the delivery date. The continuous enrollment criterion requires the member to be enrolled 28 days prior to the delivery date through the delivery date with no gaps in enrollment. The member must also have a gestational age assessment or gestational age diagnosis within one day of the delivery date. Next slide.

The second rate is follow-up on positive screen. This is defined as all deliveries from the depression screening numerator with a positive finding for depression during pregnancy.

The measure includes numerators for two rates: depression screening -- deliveries in which members had a documented result for depression screening using an age-appropriate standardized screening instrument performed during pregnancy (on or between pregnancy start date and the delivery date). The second rate is follow-up on positive screen: deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen, 31 days total. Follow-up care is defined as any of the following; an outpatient antidepressant, telephone, e-Visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. Next slide.

Follow-up care is also considered: a depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition; a behavioral health encounter including assessment, therapy, collaborative care, or medication management; a dispensed medication, or documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up -- i.e., a negative screen – on the same day as a positive screen on a brief screening instrument. The HEDIS measurement year 2024 measurement specifications include stratifications by race and ethnicity for the Medicaid product line. Prior to adding this measure to HEDIS, NCQA tested this measure at the health plan level in Washington D.C. and Hawaii and at the provider organizational level in Colorado and New York. Since then, NCQA has continued to assess Medicaid plans' use and reporting of the measure through a series of special reports on measures leveraging the ECDS reporting standard. Reports from November 2021 and November 2022 are available online.

The Workgroup member cited NCQA, the measure developer, as stating: women with untreated depression during pregnancy are at risk for developing severe postpartum depression and suicidality and of delivering premature or low birthweight infants. Postpartum depression hinders important caregiving activities and infant attachment and bonding, which can lead to developmental disorders that last into adolescence. We also note that this measure was previously discussed by the Workgroup at the 2021 Core Sets Annual Review meeting in

conjunction with the Postpartum Depression Screening and Follow-Up measure. The Workgroup prioritized recommending the Postpartum Depression Screening and Follow-Up measure and did not recommend the Prenatal Depression Screening and Follow-Up measure for addition to the Core Sets. As Alli mentioned earlier today, CMS deferred a decision on adding the postpartum measure to the Core Sets pending further assessment of how the proprietary nature of this ECDS reporting method could impact the feasibility and viability of the measure for state-level reporting. However, the Workgroup should consider this measure on its own merits, independent of CMS's deferred decision on whether to add other ECDS measures to the Core Sets. Next slide.

Now I'll pass it back to Margo to facilitate the Workgroup discussion.

Margo Rosenbach:

Thank you, Caitlyn. We'll now invite discussion about the Prenatal Depression Screening and Follow-Up measure from Workgroup members. Please raise your hand if you wish to speak, and I'll call on you and unmute you when it's your turn.

I see, Joy Burkhard, you have your hand raised. You may speak.

Joy Burkhard:

Thank you, Margo. Hello, colleagues. My name is Joy Burkhard. I'm the Founder and Executive Director of the Policy Center for Maternal Mental Health. On behalf of a network of 10,000 providers, patients, health system leaders, and others, I appreciate the opportunity to have nominated this measure and the Workgroup's consideration of this measure. I also want to be sure the Workgroup members know that I spent nearly 24 years at a health plan; and for many of those years led our health plan's Quality Management Accreditation Program, and so have deep appreciation for the challenges that come with HEDIS data collection and reporting.

As many of you may also be aware, maternal mental health disorders, such as depression and anxiety, are well-recognized as the leading complications of birth. According to the CDC, suicide and overdose are the leading causes of pregnancy-related death in the United States. What many people don't understand is that new onset of maternal mental health disorders, such as depression, happen as frequently in pregnancy as in the postpartum period. Some studies suggest these onsets occur even more frequently in pregnancy. Maternal stress and anxiety and depression are also well-recognized as a leading cause of preterm birth and low birthweight deliveries, as we've just heard. Some patients, providers, and payers are also very deeply concerned with preterm births and low birthweight deliveries. Further, research supports that untreated depression in pregnancy can carry over into the postpartum period; and those with untreated prenatal depression are also at higher risk of suicide. It's important to detect challenges not only in the postpartum period but also in pregnancy for the sake of mothers and babies and children's health and well-being. The Alliance for Innovation on Maternal Health, an initiative funded by HRSA and led by the American College of Obstetricians and Gynecologists, rereleased its recommendations to screen in pregnancy and in the postpartum period in the form of a bundle in 2023. It was released as a primary bundle that states should focus on implementing to improve maternal health. The recommendation was moved into this primary category because of the new HEDIS measures.

Regarding potential measure collection concerns, particularly in states that reimburse through global maternal rates to obstetric care providers, there are two pathways that I wanted to point

out for states to consider for data collection. One is collection through plan-level case management programs, which is a data source allowed through ECDS measurement collection; and many plans already have preexisting case management programs to support reduction in preterm birth and are already offering screening. Some states are exploring, and have already published guidance regarding reimbursement to obstetric care providers for screening on a fee-for-service basis. These states include California, Arizona, and Colorado to name a few. Finally, at a time when many women are no longer offered a choice of whether to have a baby in this country, the time really is now for state Medicaid agencies and their plan partners to prioritize maternal depression screening starting in pregnancy so expecting mothers have the greatest opportunity to receive early intervention, treatment, and follow-up care. Thank you.

Margo Rosenbach:

Thank you, Joy. Kai, you are next.

Kai Tao:

You know, I definitely agree that it is critical that we think about maternal health in the peripartum years. I feel like over the last two decades where I have been a nurse midwife, seen Medicaid-only patients primarily, our health systems have done vast improvements in making sure that routine screening for children and adults are happening almost as a vital sign. This is one of the key ways we know we can de-silo and destigmatize mental health and get people the help they need. I am just concerned about one more measure. Like I said, it's not because it's not important but I think it's being done already. Not only in the more conventional OB prenatal setting, but also, we are seeing the advent of a lot of – which is amazing – supportive care, whether we're looking at doulas, home visitors, family case managers, community health workers. I realize these are all different disciplines, but they are often being called upon, especially with our maternal morbidity and mortality outcomes – the disparate health outcomes that we're seeing. They're also doing it, which is great because like we said, this is a serious issue that needs addressing, especially in a vulnerable peripartum care. I just don't see the need though – and of course we're doing it in postpartum depression as well. So, I am just hesitant to add this as one more measurement that our health centers will already feel like they're already doing; and I'm just not sure of the true value. Thank you.

Margo Rosenbach:

Thank you, Kai. Lisa Satterfield?

Lisa Satterfield:

Am I unmuted?

Margo Rosenbach:

You are unmuted.

Lisa Satterfield:

Okay, great, thank you. The American College of Obstetricians and Gynecologists supports the addition of this measure into the Core Set. We have two new guidance documents – the Screening and Diagnosis of Mental Health Disorders in the Pregnancy and Postpartum Period and then the subsequent one, the Treatment of Mental Health Conditions in the Pregnancy and

Postpartum Period. We have policy statements and physician statements that say that every woman should receive screening during their well visits and as well as during their prenatal period and postpartum period. So, this is an important measure. We know that mental health disorders are increasing, as Joy indicated. There has been a recent study of eight million deliveries that found from 2006 to 2015, perinatal mood and anxiety disorders increased from 18.4 per 1,000 deliveries to 40.4 per 1,000 deliveries. Then also the severe mental illness is increasingly becoming a problem. That has also doubled in the past ten years. So, this is an important measure. We do have concerns about the feasibility and believe that like my colleague, the certified nurse midwife Kai, we believe that this is actually being done more than it's being reported due to the way obstetric care is delivered and billed for in the global OB bundle. So, it will be interesting to see what mechanisms the state Medicaid programs can develop to either incentivize more screening, be it reimbursed for the screening outside of the global code or make reporting easy without increasing administrative burden. Thank you.

Margo Rosenbach:

Thank you so much. We have a lot of people lined up to speak. This is great. Next up is Jakenna Lebsock.

Jakenna Lebsock:

Can you hear me?

Margo Rosenbach:

Not very well, can you speak a little bit louder?

Jakenna Lebsock:

I'll try to. Is that any better?

Margo Rosenbach:

It's a little better.

Jakenna Lebsock:

Okay, I am definitely in support of this measure. I think it's really important. I think states would generally agree; however, I do want to kind of echo some of Kai's comments in that any time a new measure is introduced, I know Arizona collectively holds their breath; and I think I'm not alone with other states in that we have to be mindful of workload. So generally, I'm very supportive. I think this is absolutely critical, but I don't want to understate how much new measures add to the burden that states are already taking on in terms of trying to get everything out and to manage the number of priorities that are in place. So that would be what I would offer for consideration. Then if it is approved by the Workgroup and ultimately by CMS, I think this is a measure where stratification is really important; and we really do look at some of the different impacts that are playing into how care is being received or lack thereof. So that's going to be really critical as we get down the road a bit with this work.

Margo Rosenbach:

Thank you, Jakenna. Next up is Lisa Romero from CDC.

Lisa Romero:

[Inaudible]…CDC's Division of Reproductive Health. CDC supports the recommendation to add a Prenatal Depression Screening and Follow-Up measure to the CMS 2026 Adult Core Set. This measure will complement the postpartum depression screening measure that will be implemented in the 2025 Core Set and is important to add as our PRAMS data show lower provider screening in the prenatal versus postpartum period. Together the measures will comprehensively cover the full perinatal period and are an important piece of our collective efforts to prevent and address the nation's maternal health crisis. Thank you.

Margo Rosenbach:

Thank you, Lisa. I just wanted to clarify one thing, that CMS has not yet announced the 2025 Core Sets, so it's not definitive that this measure will be added – that the Postpartum Screening measure would be added to the 2025 Core Sets. So, I don't want anyone to think that decision has been made, that you've just missed out on that decision. As I mentioned earlier in response to another question, that decision should be included in the 2025 State Health Official letter that CMS is currently working on; and that will be released in the spring. So, while the Workgroup did discuss it again last year and reaffirmed its support for that measure, it has not yet been decided on and released by CMS. All right with that, thank you, Lisa. We have a lot of other people in the queue. So Stacey Bartell, you're next.

Stacey Bartell:

Thank you, can you hear me?

Margo Rosenbach:

Yes.

Stacey Bartell:

Good, thanks. I represent the American Academy of Family Practice, and we would like to support this measure. We feel in light of the large mental health crisis and maternal mental health crisis in addition to our high-risk population that this could benefit our care for these patients. I understand everyone's concern about measurement, and I know we all think we're doing this work. But one of the things we've learned through the years in quality is we don't know how well we're doing until we start to measure something. That's all I had to note, thanks.

Margo Rosenbach:

Thanks, Stacey. Okay. Next up, Anne Edwards.

Anne Edwards:

Thank you, can you hear me now?

Margo Rosenbach:

Yes.

Anne Edwards:

Great, so this is a really important measure when we think about strategic priorities. I will also note this is a measure that has the potential to really positively impact the health care delivery and health of at least two individuals. So as a pediatrician, appreciate this being offered. I always struggle a little bit. We always get to this point on some of our strategic priorities and what's really helpful for the health; and then when we look at technical feasibility elements and the burden of measures, that always becomes a discussion point. I guess I have a question if there's anyone on the call who has experience with this that might be able to comment and offer something for the Workgroup.

Margo Rosenbach:

Thanks, Anne, that's a great question. Lindsay, are you on – Lindsay Cogan – and able to speak about New York...or anyone else? Lindsay, I see you just popped up. I think you can unmute.

Lindsay Cogan:

Sure, so we have been collecting this measure for a couple of years now through our managed care organizations. It is, again, one of a suite of measures in which involves really pulling together information across many different sources. So, while we do pay for – I believe we pay for prenatal and postpartum depression screening. So, we do have the advantage of having G codes that will pop up in administrative data, and that is helpful. So, states that are paying for that extra screen may be able to really leverage their administrative claims data to give them a good idea. The follow-up rate in any of these measures is challenging, right, because that often is captured in notes or in other sort of unstructured data elements. So, the follow-up tends to be the more challenging of the two rates in any of our screening for anything and then looking to see if there is adequate follow-up. As we move in this direction – and we'll be talking about another measure similarly that talks about sort of the screening components all of, I think, tomorrow. That being said, I agree that we don't want to pass the burden on in too many areas. I think that I would recommend we prioritize. I think we have the postpartum that we've prioritized as a place to start with, get that up and going – not to say that one is more important than the other, of course not. But that might be – it's really helpful for us as we're discussing these measures. It's very hard when we don't understand what the decision is on the 2025. I'll just say that. If we knew that, I think we'd be better informed about whether we wanted to put forward yet another measure if it was just going to fall to sort of that same fate. So, I hope that's helpful. The rates are particularly low when we look at the way the data is captured, if that helps.

Margo Rosenbach:

Lindsay, what I would suggest – and for the rest of the Workgroup – to think of this measure on its own merits and not together with the postpartum depression screening measure. CMS may add it, may not, may add it for '25, may defer it a little bit longer – hard to say. But I think the Workgroup should think about it in relation to this measure on its own merits and not be overly focused on what CMS's decision is for 2025. Just noting that CMS is working actively on its decision but does not have one yet. So, I hope that that is something that the Workgroup can kind of look beyond and just look at this measure in terms of what it would add to the Core Sets with the Postpartum Depression Screening measure in combination or, if not recommended, what the loss would be in terms of thinking about maternal health or maternal and infant health. I hope that's helpful. David, I think you might have had some experience also in Pennsylvania?

David Kelley:

Yes, thank you so much. So, we have -- for probably over a decade -- have done chart review on both prenatal and postpartum depression screening and then follow-up. We also require our managed care plans, starting in measurement year I think 2021, to actually do the ECDS measure for both prenatal and postpartum. So, I will share with you some of our insights in that, and I'll give you the actual rates. So, for the ECDS measure – and these are all publicly on our website, at least the 2021s are. So for prenatal screening, only 26% of individuals screened; and the follow-up was 41%. Of those that screened positive, only 41% actually had follow-up. That was the first year; and again, whenever you do or MCOs do a measure in the first year, things wobble a little bit. Again, that's our average across all of our MCOs. Then in measurement year 2022, the screening rate went up to 31.6%; and of those that screened positive, the treatment rate went up to 50%. So, we did see about almost an 8.5% increase in that follow up. Now, one of the things that -- as I mentioned, we've been doing chart reviews, and this is a validated measure that we developed with our EQRO over a decade ago. I think there were some comments about does measure reflect what's happening in actual clinical care? In my mind, the answer is it does not necessarily. So, when we look at our screening rates from actual chart reviews from validated randomly selected charts, in 2021 72% -- almost 73% were screened. Twenty percent -- again, this is prenatal screening – almost 21% actually screened positive, and our follow up there was 77.3%. So, comparing that again to the ECDS measure, much higher screening rates and significantly higher follow-up. Now again, I know we're comparing apples perhaps to oranges; but this is a chart review looking at the nitty-gritty of what's going on clinically. We did the same thing in 2022, and I'll happily say our screening rate went up to 86%. And again, about 22% of folks screened positive prenatally, and 82% actually got treatment. So I just want to share with you that we've looked at both the ECDS measures and these Pennsylvania performance measures that have been validated by our EQRO. It's a pretty intensive chart review. So just wanted to share our experience.

Now with that being said, I would say that – and I've been helping to put together the Core Sets since they both started for both adults and children. I will say that especially in the early years, some of us really pushed for pushing the envelope and getting out there in front and really suggesting measures that maybe weren't exactly perfect. From my standpoint, I would say that even though I have some of these concerns, this is such an important topic that we know from some of our studies that we've done that this is a key contributor to maternal mortality and morbidity. This is just of such importance that it really should be, in my mind, really should be part of the Core Set. With that being said, I will also comment on – I know we're supposed to consider this independently, but many states have maternity bundles and, quite honestly, if you're at the clinical level, you'll understand this. If you have the infrastructure in place to screen and report on prenatal depression, you have that same capability and infrastructure built to do postpartum. So, I would really advocate if you're going to do one, you should do the other. Anyway, those are my thoughts. That's our experience. Thanks so much.

Margo Rosenbach:

Thank you, David. Linette Scott?

Linette Scott:

Hello, thank you so much. I just wanted to share – well, I have a question and then sharing some of our experience. So, the question piece is that in the Core Set we do have the screening depression measure – so the CDF – that is for all ages. So, the question is around having somebody maybe describe are the measure specifications the same for that depression screening measure that we have to do for our members as compared to the depression

screening for those being proposed in this measure? When I look at it, I think that there's similarities; but there's also differences. So, one question just from the implementation arm. If somebody who's more familiar with it than I am, could speak to what extent there's similarities/differences in methodology for the existing cross-cutting depression screening versus this new prenatal screening measure – so just keeping it in context of what's in our set already.

That being said, in California we have been doing the prenatal/postpartum screening that matches what's being proposed here. For the first time this past year, our plans reported. So, we just did this with our managed care plans. As has been said before, there's quite a range in the reporting. Some plans have good reporting; some have very, very low reporting. It was the first time we had done that measure. So there is definitely, as we implement new measures -- especially in the context of whether this is in the bundle that's required reporting versus not -- what that onramp relates to in terms of states and plans being able to work on this. The other part though that I would flag is in California, we're – and I think somewhere close to 90% managed care headed towards 99% managed care. So, implementing through our managed care plans works, but there are many states that still have significant fee-for-service. So implementing these measures in the fee-for-service environment as opposed to the managed care environment, there may be some very different considerations in terms of feasibility, workload, effort. You've heard people say chart reviews frequently related to these measures. So would just kind of flag that for consideration as well. Thanks.

Margo Rosenbach:

Thanks, Linette. Rachel La Croix?

Rachel La Croix:

All right, can you hear me?

Margo Rosenbach:

Yes.

Rachel La Croix:

Okay, thank you. First, I just want to thank Lindsay, David, and Linette for talking about their experience with this measure so far and some of the struggles with it and some of the improvements that you've seen. This is a measure that we're including in our next managed care contract, so we haven't had the opportunity to see the capacity our plans have had to really report on this or what rates look like yet. But we agree that it's a very important measure. One of the things I thought of as everyone was discussing this as well is remembering the conversation we had a number of Core Set Review Workgroups ago. A number of years ago, I think we were discussing the Timeliness of Prenatal Care measure; and I remember folks having a little frustration with that in terms of just looking to see did someone have a visit, not really looking at the content of that visit or exactly what was happening as part of that prenatal care for the members. So, I feel like this measure, complemented by the postpartum depression screening measure – those really do give us a little more insight into some of the elements of care and follow-up being provided to pregnant women. So, I feel like this does help address something we had talked about as a potential gap in the past.

Margo Rosenbach:

Thanks, Rachel. Rich Antonelli?

Rich Antonelli:

Thank you, what wonderful, robust conversation! I need a little bit more information because if it's available, I haven't seen it. I'll beg everybody's indulgence. One is I'd like to hear about the experience of stratifying of this measure so far. I know that it's been tried in a few states at the health plan and provider level. The second one is reviewing the exclusionary criteria of low 37-week gestation fall out of the measure. But I'm wondering is the ACOG bundle or the recommendation sufficient to give us a window of when the prenatal screen would occur. So, in other words, I am very mindful, Margo, of considering the measure on its own; but obviously, thinking about the potential for complementarity. But technically, could these two screenings happen inside of a 40-day window instead of over a broader period of time? So those are my two questions – experience with stratification in field testing and is there an ACOG window so we kind of get a sense of just how "pre" the prenatal screening is done, especially if there was a complementary postpartum.

Margo Rosenbach:

Thanks, Rich. Lisa Satterfield, are you able to answer the question about the bundle, and do we have anybody from NCQA that could answer the question about stratification?

Lisa Satterfield:

This is Lisa. I'm looking at the guidance right now just to confirm what I think it is. But my last read was it could – I'm going to defer to NCQA first, and then I will get back to you guys.

Margo Rosenbach:

Do we have anyone from NCQA to speak about stratification or any one of our states that has used it and stratified? I see Ashley Corbett. Can you unmute, Ashley? You should be unmuted.

Ashley Corbett:

Hello, can you hear me?

Margo Rosenbach:

Yes, we can.

Ashley Corbett:

Great, yes, so in relation to how we stratified the measure out currently in its state is by the product line, race, and ethnicity. So that is where we are currently stratifying the information out. I think specific to stratifying beyond that, we do not have testing data. However, I do have Lindsey Roth, who is another colleague on the call, who did some measure development for the PND-E and also the PDS-E – so both the prenatal and postpartum – who might be able to share more from that. But that is the primary areas that we have stratified the data out to currently.

Margo Rosenbach:

Ashley or Lindsey, can you say anything more on the race and ethnicity stratification in particular for the Medicaid product line?

Lindsey Roth:

Can you hear me?

Margo Rosenbach:

Yes, Lindsey, we can hear you.

Lindsey Roth:

Great. Unfortunately, I don't have too much more to add. For the HEDIS measure, we added the race and ethnicity stratification to the measure starting in measurement year 2023 and we'll actually be getting in the first-year data on that this coming summer, which we'll take a closer look at. But right now, we don't have anything specific to share about what that data looks like. We do know that – we did apply race and ethnicity stratification to other HEDIS measures starting in measurement year 2022, and just broadly and not surprisingly do see some feasibility issues with health plans being able to identify complete data – not surprising. I believe there are some publications we've put out just sharing the preliminary findings from that which we could share. But with respect to this particular measure, we don't yet have that data.

Margo Rosenbach:

All right, thank you. Lisa, do you have a response on the window?

Lisa Satterfield:

Yes, I do. So, our recommendations are to screen twice during pregnancy and at least once during postpartum. The recommendations say that the initial visit -- now keep in mind the initial visit can have a pretty broad window, depending when the patient first presents with the pregnancy. But it is on initial visit, and then then it's recommended subsequently in the middle of pregnancy, though we don't really have a specific date; but it is recommended twice before delivery if that helps.

Margo Rosenbach:

That's great, thank you. We're going to move on. We still have a number of people in the queue, and then I'm sure we're going to have some public comment. Ben Anderson, you're next.

Ben Anderson:

Yes, hi, thank you. I'm so grateful that this measure has been recommended for a number of reasons. I'll keep my comments brief given the robust discussion we've had. Really just want to echo that, yes, this measure is additive for patients and consumers who need and want these screenings to be happening so that services and assistance can be identified prenatally, not just during the postpartum period. Also want to echo that it's good to see what's happening and see what improvement is needed, even though we suspect that perhaps some of this screening and referral is already occurring. Then third, and I think most importantly, we continue to be in the midst of a growing and worsening maternal health crisis; and maternal health outcomes continue to get worse year after year on a number of levels. I think we do need additional tools in the toolbox when it comes to measurement and holding plans and providers accountable for what's happening in the Medicaid space, especially at this moment. So, while I think it may be appropriate in other circumstances to really hone in on what's like the one thing that we've got

to prioritize, I think we're in a place in maternal health in America right now where we do need more tools. I think until – and I'm concerned that maybe we're getting a little fatigued potentially perhaps around the maternal health crisis because I think there's been understanding around what that is for some time. But what I think people maybe lose sight of is the problems are pervasive; and I think the more data we're collecting, I think the more we're seeing that we really need to be doing better to turn the ship around. This, I think, is a necessary tool that's a part of that. Thank you.

Margo Rosenbach:

Thank you, Ben. Angie Rohan from CDC?

Angela Rohan:

I just wanted to acknowledge first the reporting burden concerns that have been mentioned. I think this has been a really thoughtful discussion. I think for this measure specifically just wanted to emphasize the importance of that prenatal period for addressing prenatal depression. We have found in our PRAMS survey that postpartum depressive symptoms are actually higher among those with depression before or during pregnancy. So again, that prenatal time is just really important for early identification, referral, and engagement in treatment – especially knowing that there have been some reported lower rates of screening in the prenatal versus the postpartum period. Then one just additional note is that we know there's not universal engagement in postpartum care, and especially in states where eligibility or coverage might differ or change in that postpartum period. So again, that kind of while we have engagement in the prenatal space, it's just a really important time for addressing perinatal depression and an opportunity for tracking and measuring. Thank you.

Margo Rosenbach:

Thanks, Angie. Next up, Kim Elliott.

Kim Elliott:

Hi, I don't want to repeat what other people have already said because we are very short on time in some of these sessions; but what Ben said is really what I was going to say – that we are seeing so many negatives in maternal health outcomes right now and that that problem is getting worse. What Lindsay said, what Linette said, what David said and Rachel said related to the importance of the measure, and they're not necessarily seeing the results that they would like yet and the challenges of course in this measure. But a lot of the measures that we've included in the Core Set have had their degree of challenges; and with this one being an ECDS, we're clearly not going to necessarily have all of the data and resources coming in to report. So, there's one more challenge for us. But the importance in really shining the spotlight on maternal care/maternal outcomes, I think it's a measure that's really an important one to consider for the Core Set.

Margo Rosenbach:

Thanks, Kim. I see, Jakenna and Lisa, you still have your hands raised. Do you have other comments or lower your – oh, great, okay. I think our last comment will be Jeff Huebner.

Jeff Huebner:

Yeah, thanks so much. Agree with the great discussion and a lot of comments have covered mine. I would just add too -- I mean, from my vantage point as family doc, Medicaid, CMO, and also the privilege to participate in our state's Maternal Mortality Review Team, getting to see up close the cases of maternal death and the rising incidents and the huge contribution of unmanaged and untreated, sometimes unscreened, depression and other mental health issues is really striking. I think this is a great time for us to consider adding this measure. I would just say too in regards to the burden, I'm excited about the bundled approach and agree with the comments around hopefully clinical systems are able to do pre and post well. But I think one of the key parts of this measure is really the engagement. Even if screening is improving engagement and helping to assist positive screens to get the care they need in a meaningful way, that's not always happening. I think hopefully this measure will help. Thank you.

Margo Rosenbach:

I see two more hands, David Kelley and Linette Scott. Do you have further comments before we move to public comments? David?

David Kelley:

Real quickly, I was checking with staff for the prenatal and postpartum. The chart reviews I had mentioned we had stratified by race and ethnicity, and I'm waiting for a final response back from our staff. But I believe that when we've measured that, there have been some equity gaps in both the screening component and the follow-up. I just wanted to let folks know that, again, this is important; and there may very well be equity gaps here within this particular measure that we could really be focused on to reduce – to improve maternal health and reduce maternal mortality. Thanks.

Margo Rosenbach:

Thank you, David. And Linette?

Linette Scott:

Thank you so much. I just wanted to kind of go back because I didn't hear anybody respond to my question, which is we have Screening for Depression and Follow-Up Plan as part of the Adult Core Set now that is a CMS measure. So, I would presume we are doing that measure on all adults, including those that are in the prenatal and postpartum time period. But we're now talking about adding an additional measure that has slightly different specifications from NCQA as opposed to CMS in terms of the measure owner and focusing on particularly the prenatal time period. So, I agree with everybody's comments about the importance. My question is around the logistics of having two different screening for depression measures from two different stewards that are touching the same population on the Core Set. I didn't hear anybody respond to that question. I guess I was hoping somebody might be able to explain that and whether we should add this given we already have the other. It just seems like a duplication, and we could use the one we have and stratify it by the postnatal and prenatal populations if we were doing one measure; or we could switch both. We could switch all of them to the NCQA measure instead of the CMS measure, but obviously nobody recommended removing the CMS screening for depression measure this time around.

Margo Rosenbach:

That's right, Linette. I can't answer your question perfectly except to say that they are different. The prenatal and postpartum measures are much more tailored to the specifics in the numerators and the denominators targeted to the specific populations and also the instruments that would be used appropriately for these populations. So, I hear what you're saying is that we have two separate measures, but they are different. I think -- I would just advise the Workgroup to consider the fact that we do already have this measure, the CDF measure; but this is really to focus much more specifically on the content of depression screening within the prenatal and postpartum periods. And with that, I thank you, Linette; and thank you, everyone, for another robust conversation. If we have public comment, please raise your hand now so that we can have public comment and then proceed to a vote. Do we have any public comment? Is there anyone that wants to make public comment before we move to the vote?

Not hearing or seeing public comment, I think we should move to the vote. Alli and Talia, it's all yours.

Alli Steiner:

All right, thanks, Margo. I'll open up the vote now. Okay, so for the next vote, should the Prenatal Depression Screening and Follow-Up measure be added to the Core Set? The options are yes, I recommend adding this measure to the Core Set, and no, I do not recommend adding this measure to the Core Set. The voting is open; and as a reminder, you can refresh your browser if the question does not appear. All right, it looks like we may be missing James Crall's vote. James, if you're with us, can you try maybe submitting it again or put it into the Q&A and we can submit it on your behalf? All right, now we can close the vote.

Okay, so for the results: 85% of Workgroup members voted yes. That does meet the threshold for recommendation. The Prenatal Depression Screening and Follow-Up measure is recommended by the Workgroup for addition to the 2026 Core Set.

So now I'll pass it back to Margo.

Margo Rosenbach:

Thank you, Alli and Talia and the rest of the team, for keeping track of all those votes – a little bit tense while we're waiting for those last few votes. Next slide, please.

So, this brings us to the end of our measure discussion today. Thank you, everyone, for all the robust conversations. We appreciate everyone's contributions. So, to recap, the Workgroup considered two measures for removal and recommended the Use of Opioids at High Dosage in Persons Without Cancer, the OHD-AD measure, recommended that for removal but did not recommend the Initiation and Engagement of Substance Use Disorder Treatment, or IET-AD, did not recommend that for removal. The Workgroup considered one measure for addition and recommended the Prenatal Depression Screening and Follow-Up measure for addition. So, thank you, everyone, for all of the discussion. It was certainly very, very rich and informative. Next slide, please.

Now I wanted to preview the agenda for tomorrow. A reminder that the meeting is scheduled to start at 11:00 a.m. and end at 2:30 p.m., so a slightly shorter agenda for tomorrow. We'll discuss the final measure suggested for addition: Social Need Screening and Intervention. I think it was Lindsay who mentioned it's also an ECDS measure with screening and intervention follow-up, so looking forward to that conversation. We will also discuss priority gap areas and criteria for the Public Call for Measures for the 2027 Child and Adult Core Sets, and then provide a recap

of the meeting and discuss future directions. We'll discuss next steps in the Core Set Annual Review process and have a final opportunity for public comment. Also, as I mentioned earlier, that will be a good time to also recap on potential technical assistance needs. Next slide.

So now I wanted to preview our plan for tomorrow's discussion of the Public Call for Measures. This is a new process that we're going to be having tomorrow to prepare for the Public Call for Measures. We'll be discussing priority gap areas as well as criteria for submission. In terms of priority gap areas, the main question is: what are the priority gap areas in the current Child and Adult Core Sets that could be addressed by the Public Call for Measures to strength and improve the Core Sets? And the way we're going to do this is have a lightning round with Workgroup members. We ask you to mention one priority gap area or plus-one a gap area mentioned by another Workgroup member, and please be succinct. We know that many of you have many measures and gap areas on your wish list, but please think of one so that we can move through this very quickly. Also, keep in mind the purposes and uses of the Core Sets. We'll be talking much more about that tomorrow as we prepare, but wanted to give you a head start to think about this overnight. In terms of the criteria for submission, thinking about the 2026 Call for Measures criteria, which Caitlyn mentioned earlier, what changes would you suggest for the 2027 Public Call for Measures? The minimum technical feasibility requirements, we certainly will continue those, actionability and strategic priority, other considerations, and any other Criteria? We'll also offer another opportunity for public comment after the Workgroup discussion. Next slide.

With that, before we adjourn, I'd like to turn to our co-chairs, Kim and Rachel, and ask do you have any final remarks to close out the meeting today? Maybe, Rachel, this time you go first.

Rachel La Croix:

All right, can you hear me?

Margo Rosenbach:

Yes.

Rachel La Croix:

Okay, thank you. I just would like to tell everyone thank you for all of the good conversation today. I really appreciate all of the Workgroup members sharing their concerns/hopes for some of these measures moving forward, particularly with the recommendation for adding a measure, but really sharing experiences and concerns from across the spectrum with the different measure changes that we've talked about today. I know I've learned a lot, and I'm sure I'm not the only one; but it really has been a good, robust conversation and given us a lot of food for thought as we considered these measure changes for the future. I'm definitely looking forward to our conversations tomorrow and also just want to thank the Mathematica team again for keeping this so well organized and keeping us on track as we walk through the different steps involved in this process. Thank you.

Kim Elliott:

Hi, this is Kim. I also want to thank everyone for a very full and very productive day today. The level of engagement of our Workgroup members – it always just amazes me -- the perspectives people bring and the subject matter expertise and their experience. Initially, I was really struck by the comments of CMS, Ms. Stockmann, made on the work that we're doing as a Workgroup

and some of the significant milestones – such as how many people we touch, the 85 million; the Core Sets and how they're really focused on quality and access. All of the measures we're selecting through this Workgroup really do focus on the Medicaid and the CHIP population. So those types of things are really important as we work through today and tomorrow of course as well. I do find it kind of amazing too how much progress we've made, which was also discussed early today, related to how many states are reporting measures and how many are using the Core Sets specifications to do the reporting. We've come a long way the last several years.

I guess for tomorrow we have one more measure to discuss. Based on discussions in our Workgroup today, I think it's going to be a very fruitful discussion as we move into the gap discussion. In each of the sessions today, each of the measures that we discussed, different individuals did bring up areas that they identified gaps or things where we might find some opportunity to improve the Core Set. So, I think it's going to be a very robust discussion. I'm really looking forward to it. So again, thank you to everyone today for your very hard work not only today but all of the work done leading up to it and of course for all of the work that we do every day in measuring and validating the measures that are produced. So, thank you, everyone.

Margo Rosenbach:

Next slide, please. Well, thank you, Kim and Rachel, for your comments.

And thank you, everyone. It's very clear, as Kim and Rachel said, so much preparation went into this meeting. Everyone came very informed with lots of great ideas, lots of perspectives shared; and I think it's just been wonderfully fun to reflect on the future of the Core Sets. We're getting close to the end of the day. We'll begin promptly at 11:00 a.m. Eastern again tomorrow. We ask Workgroup members to sign in about ten minutes early if possible.

And this concludes Day 1 of the 2026 Child and Adult Core Sets Annual Review Meeting. Enjoy the rest of your day. We hope you'll join us again tomorrow at 11:00 a.m. Eastern, and we are adjourned for the day, thank you.