2027 Medicaid Health Home Core Sets Annual Review: Meeting to Review Measures for the 2027 Health Home Core Sets Transcript September 10, 2025, 11:00 AM – 3:00 PM ET

Grace Reynolds:

Hello, everyone. My name is Grace Reynolds, and I'm pleased to welcome you to the Medicaid Health Home Core Sets Annual Review Meeting to Review Measures for the 2027 Review. Before we get started, we wanted to cover a few technical instructions. 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 Control-Shift-A on your keyboard to enable closed captioning.

All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for Workgroup members and the public to make comments. To make a comment, please use the Raised 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 webinar. 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. If you have any technical issues during today's webinar, 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. With that, I'll hand it over to Emily Costello.

Emily Costello:

Thanks, Grace. Next slide, please. Hello, everyone. My name is Emily Costello, and I am an advisory services analyst at Mathematica with Mathematica's Technical Assistance and Analytic Support team for the Medicaid and CHIP Quality Measurement and Improvement Program, which is sponsored by the Center for Medicaid and CHIP Services. It is my pleasure to welcome you to the voting meeting for the 2027 Annual Review of the Medicaid Health Home Core Sets. Thank you to our Workgroup members, federal colleagues, and members of the public for joining us for this virtual meeting. Let's take a moment to review today's agenda.

After the introductions, we will move into a brief overview of the health home programs. Next, we will recap the approach to the measure review and voting process, including the criteria for measure review. Following that, we will discuss the measure that was suggested for addition to the 2027 1945 Health Home Core Set. There were no measures suggested for addition to the 1945A Health Home Core Set, and

there were no measures suggested for removal from either of the Health Home Core Sets. Following the Workgroup discussion and opportunity for public comment, the Workgroup will vote on the measure.

After the vote, we will transition into discussions to inform future Core Sets, including the gaps discussion and the Workgroup's reflection on measures and future directions. We will close the meeting with a final opportunity for public comment and a recap of next steps. Next slide. And next slide.

I'd like to acknowledge my colleagues at Mathematica and Aurrera, who are part of the Health Home Core Set Review team. Since the call for measures closed earlier this year, they have been very busy gathering information on the measures suggested for addition and developing the materials for the Workgroup's review of the measures. Thank you, team, for your efforts. Next slide.

This slide reinforces the objectives for today's voting meeting. We will review the measures suggested for addition to the 2027 1945 Medicaid Health Home Core Set. Following the vote, we will engage in discussions related to opportunities for future updates, future measure development, and our always-robust gaps discussion. These discussions are key to informing future Core Set Workgroups. Finally, there will also be an opportunity for public comment. I'd like to pause for a moment and note that we are committed to a robust, rigorous, and transparent meeting process despite the virtual format.

That said, we acknowledge that attendees may sometimes experience challenges with the virtual meeting format. I hope that everyone will be patient as we all do our best to adhere to the agenda and fulfill the objectives of the meeting. Some of you may be wondering why we are not using video for this meeting. As we've mentioned previously, 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 Health Home 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 several hours a day in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning back from the break so that we can have everyone present for the discussion and voting on the measure.

Related to that, we want to make sure that all Workgroup members who wish to speak may do so. When you want to make a comment or ask a question, please use the “Raise Hand” feature in WebEx and 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. Next slide.

I would now like to introduce the Workgroup Co-chairs Jeff Schiff and Kim Elliott to make some remarks. Jeff, if you wouldn't mind going first.

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Jeff Schiff:

Good morning or afternoon, everyone. It's a pleasure to be here. I want to just welcome both the committee members and also the public audience who's here as well as the federal partners who are listening in. I just want to say a minute about what the health home represents. I think we need to just ground ourselves in the fact that the health home program is really designed to support the care of those with chronic illness, including those with mental health illnesses. And this is our opportunity to assure that this program has some uniform quality measurement across the board. It's really a unique thing that the federal Medicaid program looks at this program in this way.

There are other mechanisms for care coordination, but this is one of the main ones. I want to say that one of the challenges we've always had with health home measures is trying to make them as rigorous as possible and also make sure that they are in some ways diagnosis-agnostic because there are many chronic illnesses that could potentially qualify. And then I'll just close my short remarks by just saying that I'm looking forward to a thorough discussion. And I want to thank Mathematica and the folks at CMCS for their support of this work. Kim?

Kim Elliott:

Thank you, Jeff. I agree with everything you just said. I'd also like to welcome everyone. I'm looking forward to working with all of you and I'm happy to do this work on the Health Home Core Set. Like you, I'm excited to be part of this important process. The Workgroup is charged with assessing the 1945 and 1945A Medicaid Health Home Core Set measures, identifying gaps in the Core Set, and of course, making recommendations that will strengthen and improve the Health Home Core Set.

As I reviewed the proposed measures, I thought one of the important things is that we consider whether the measure reflects the population served in the health home programs. Also considering whether states have the data and information available to report the measure. And having the ability to stratify the measure is really important for this one as well. And whether the measure is bridging any of the gaps that we've identified over the last several meetings in the 1945 Health Home Core Set.

As I looked at the proposed measure, I considered the qualifications for the measure and the Health Home Core Set and how the measure may meaningfully drive improvement in healthcare delivery and outcomes for the member, keeping the member as really the central focus of why we do the performance measure. We really want to improve outcomes and care for those individuals.

Then I considered whether there are actions that can be implemented that are feasible and viable to report at the program level and of course, in consideration of gaps in the Core Set itself. It is sometimes a bit challenging to do this because it is such a thoughtful process to identify measures that meet all of the criteria for consideration for inclusion as a core measure, particularly measures that have been tested in state Medicaid programs. However, the criteria result in a strong Core Set to drive improvement and improve outcomes and advance healthcare for individuals served through the health home program. I'm really looking forward to our work in the 2027 Health Home Core Sets.

Similar to all of you, I'm especially looking forward to the gap discussion a little later today and the thoughtful process that Mathematica has proposed for this year's gap discussion. I really want to thank you in advance for your focus and participation throughout the meeting. And of course, thank you to Mathematica and CMS for really putting together some excellent information for us to work with as we worked our way through the process. So, I'll turn it back over to you.

Emily Costello:

Thank you, Kim. And thank you both for your time and dedication to the Workgroup. Next slide, please. And 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 Health Home Core Set measures or the suggested measure that will be reviewed by the Workgroup for potential addition to the Health Home Core Set. During introductions, members are asked to disclose any interests related to the measures that will be reviewed 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. We will unmute you. You can say hello, share any disclosures you may have, or indicate that you have nothing to disclose. We also have an icebreaker to start off the meeting. We'd like you to briefly mention one thing that you are looking forward to during today's annual review meeting. When you're finished speaking, please mute yourself in the platform and lower your hand. This will allow you to unmute yourself when you would like to speak during the measures discussion. If you leave and re-enter the platform or you find you've been muted by the host due to background noise, just raise your hand and we can unmute you. Next slide.

On the next two slides, we've 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've also muted yourself on your headset or phone, please remember to unmute your own line to avoid the dreaded double mute. If you have any technical issues, please use the Q&A function in Slido for assistance. So, Kim, starting with you, please indicate whether you have a disclosure and mention one thing you're looking forward to during this year's meeting.

Kim Elliott:

Hi. I have nothing to disclose, and I'm looking forward to the gap discussion today.

Emily Costello:

Thanks, Kim. Jeff?

Jeff Schiff:

Hello again. I have nothing to disclose, and I am also looking forward to a gap discussion that—I'll just go a little more specifically—that looks at sort of measures that or needs we have that are not specific to diagnoses, but more comprehensive and holistic.

Emily Costello:

Thank you, Jeff. Next, we have Clarissa Barnes.

Clarissa Barnes:

Hello. My name is Clarissa, obviously. I don't have any disclosures or conflicts to report. While I am also looking forward to things already mentioned, I would say I'm also really interested to hear more from other partners here about sort of for the measure we're discussing, like feasibility and technical questions.

Emily Costello:

Thanks, Clarissa. Next, we have Demi Culianos.

Demi Culianos:

Hi. Good morning. I have nothing to disclose, and I am looking forward to a robust discussion on the proposed measure and learning if other states or partners have challenges with accessing the data for this measure.

Emily Costello:

Thank you. Next, we have Macy Daly.

Macy Daly:

Hi, everyone. My name is Macy Daly. I don't have any disclosures today, and I'm also looking forward to hearing everyone's discussion during the gap analysis today. Thanks.

Emily Costello:

Thank you, Macy. Next, we have Ari Houser.

Ari Houser:

Hi. Ari Houser. I have nothing to disclose, and today I'm looking forward to a discussion around the proposed measure.

Emily Costello:

Thank you. There we go. Let's see. Johnny Shults. Do we have Johnny here? All right. I think we will come back to Johnny. Next, Laura Vegas.

Laura Vegas:

Hi. This is Laura Vegas. I work with the National Association of State Directors of Developmental Disability Services. And I'm just looking forward to all the conversation around the measure recommended for addition, and I always like hearing for the public input as well.

Emily Costello:

Thank you. Laura, also confirming that you don't have any disclosures, correct?

Laura Vegas:

Oh, I'm very sorry. That's correct.

Emily Costello:

No problem. All right. Next, we have Janelle White.

Janelle White:

Hi. Good morning, everyone. Janelle White. North Carolina Medicaid. No disclosures and looking forward to hearing from partners on this convening from different sectors and different states. It's always helpful for me to understand the environmental landscape and to understand the collective areas where we can achieve these goals and then also understanding the sort of feasibility. I think someone mentioned that as well. So, it's nice to have this broad swath of colleagues to have these discussions. Thank you.

Emily Costello:

Thank you, Janelle. And then finally, Jeannie Wigglesworth. Jeannie, we're not hearing you.

Jeannie Wigglesworth:

Sorry. I'm unmuted now. Hi, this is Jeannie. I am from Connecticut with the Husky Health Behavioral Health, and I work for an administrative service organization. And I have no disclosures to report, and I am always interested in hearing from other states and how they are able to collect the data and how they're using the data is always very educational for me.

Emily Costello:

Thank you, Jeannie. And thank you all. I think this was probably our smoothest roll call yet, so I appreciate all of you. We would also like to acknowledge the participation of federal liaisons in the annual review process. The Workgroup includes representation from the Administration for Community Living, the Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality at CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, the Office of Disease Prevention, and the Substance Abuse and Mental Health Services Administration.

The inclusion of federal liaisons reflects CMS's partnership and collaboration with other agencies to ensure alignment across federal agencies and programs. Federal liaisons are non-voting members of the Workgroup, and we thank them for their participation in the annual review process as well. I'd also like to recognize the support of the staff in the Medicaid Benefits and Health Programs group in the Center for Medicaid and CHIP Services. Next slide.

Let's start with the discussion with a quick review of the Medicaid Health Home Programs for those audience members who may be joining us for the first time during this review cycle.

The Medicaid Health Home state plan option authorized under Section 1945 of the Social Security Act allows states to provide comprehensive care coordination to Medicaid beneficiaries with complex needs. Health home programs are intended to integrate physical and behavioral health along with long-term services and supports. States interested in implementing a health home program must submit a state plan

amendment, or SPA, to CMS. States can focus enrollment in 1945 Health Home Programs based on condition and geography, but cannot limit enrollment by age, delivery system, or dual eligibility status. Each health home program requires a separate SPA, and you will notice that we refer to program-level performance. Next slide.

This slide summarizes the goals of the 1945 Health Home Program, including improving care coordination, whole-person care, and improving quality of care and outcomes while reducing costs. Next slide.

As you can see here, 1945 Health Home Programs are designed for beneficiaries diagnosed with two chronic conditions, those with one chronic condition and who are at risk for a second one, or those with a serious mental illness. Chronic conditions include mental health conditions, substance use disorders, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions such as HIV or AIDS may be considered by CMS for approval. Next slide.

Now we're going to highlight the 1945A Health Home State Program option. Under Section 1945 of the Social Security Act, states are authorized to cover health home services for Medicaid-eligible children with medically complex conditions, effective October 1, 2022. A state Medicaid director letter with information on the 1945 Health Home Benefit was released on August 1, 2022, and is accessible at the link on this slide. At this time, there are no approved 1945A Health Home Programs, though there are several states that have been in communication with CMS related to the submission of a state plan amendment. Next slide.

1945A Health Home Programs coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times. The programs develop an individualized, comprehensive, pediatric, family-centered plan for children with medically complex conditions that accommodates patients' preferences. These programs aim to work in a culturally and linguistic appropriate manner with families of children with medically complex conditions. And finally, to coordinate access to sub-specialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic treatment and critical care levels as medically necessary.

Palliative services if the state provides Medicaid coverage for services and out-of-state providers furnishing care to the maximum extent practical for families of such children where medically necessary. Next slide.

This slide describes the criteria for eligibility in the 1945A Health Home Program, including the criteria for enrollment. Unlike the 1945 Health Home Programs, enrollment for this program is based on a child meeting criteria and not based on a specific condition or geographic region. Next slide.

The core services for the 1945 and 1945A Health Home Programs are similar, as you can see on this slide. In the interest of time, I won't go through them all. However, it is important to highlight one key difference. That is, care coordination for specialty and subspecialty medical services can occur with out-of-state providers as medically necessary in the 1945A Health Home Program, but these services are not core services for the 1945 program. Next slide.

Beginning with the most recently reported 2024 Core Sets, reporting is mandatory for states with approved health home programs in operation for at least six months of the reporting period. Programs are required to include all measure-eligible populations in reporting, regardless of the health home's target population. We also ask the Workgroup to consider whether a measure could be stratified by categories as referenced in the Core Sets reporting final rule, which is linked on this slide for your review. Beginning with the 2025 Core Sets reporting, states are expected to stratify a subset of mandatory measures, and stratification will be required for all eligible mandatory measures beginning with the 2028 Core Sets reporting.

Given these mandatory reporting requirements, we ask Workgroup members to consider the feasibility and viability for all programs to report a measure within two years of the measure being added to the Core Sets for all populations that are enrolled in the health home program. Next slide.

And with that foundation, let's take a moment to review the milestones for this year's review, as well as the Workgroup's charge. Next slide.

This graphic is a visual representation of the milestones for the 2027 review process. We convened this Workgroup at the orientation meeting on April 30th and opened the Public Call for Measures for the 2027 annual review that same day. On August 20th, we met to prepare for the voting meeting. Today, we are meeting to review the measures suggested for addition to the 1945 Health Home Core Set. After the voting meeting, we will prepare a draft report summarizing the Workgroup's recommendations, and this report will be made available for public comment in November. The final report, along with additional input from other partners, will be submitted to CMS for their review. This final report will help inform CMS's ultimate updates to the 2027 Health Home Core Sets. Next slide.

The Medicaid Health Home Core Sets Workgroup for the 2027 annual review is charged with assessing the 2026 Medicaid Health Home Core Sets and recommending measures for addition or removal to strengthen and improve the Medicaid Health Home Core Sets. The Workgroup should focus on recommending measures that are actionable, aligned, and appropriate for program-level reporting to ensure the measures can meaningfully drive improvement in quality of care and outcomes for Medicaid Health Home Program enrollees. Next slide.

Additionally, the annual Workgroup is designed to identify gaps in the existing Core Sets and suggest updates to strengthen and improve them. The Workgroup must determine if a measure is feasible for reporting, and if so, also consider the desirability and viability of adding the measure to the Core Sets. While there are many good quality measures, we need to keep in mind the perspective that the measures must be feasible and viable for use in program-level quality measurement and improvement in Medicaid Health Home Programs. Next slide.

With that grounding in place, let's discuss some big picture perspectives. This graphic is a visual representation of the concept of multi-level alignment of quality measures. 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. Health Home Core Set measures are considered program-level measures

because they are for distinct subpopulations within the state's Medicaid program. The Child and Adult Core Set measures are considered state-level measures because they are intended to capture 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 programs as a whole. CMS 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 on one level may lead to improvement on other levels. Moreover, alignment is intended to streamline data collection and reduce reporting burden. Next slide.

Now we will share a bit more information about the Health Home Core Sets overall to provide high-level context for the measure discussion. The 2026 1945 Health Home Core Set includes 11 measures. There is no target number of measures, either minimum or maximum. We encourage Workgroup members to consider each measure on its own merits according to the criteria that we'll discuss. All Medicaid Health Home Programs that were expected to report Health Home Core Set measures for 2024 reported all Core Set measures. Next slide.

While we will not be discussing measures suggested for addition or removal from the 2026 1945A Medicaid Health Home Core Set, it's important to keep them in mind for the gaps in future work discussion. The 2026 1945A Health Home Core Set contains six measures. All of these measures are also included on either the 1945 Health Home Core Set or the 2026 Child Core Set. There are currently no approved state plan amendments for the 1945A Health Home state plan option. Next slide.

It's important to note that measure stewards update various aspects of a quality measure's technical specifications each year. Updates can reflect a variety of factors, such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users. We have done our best to reflect the most accurate and up-to-date information about the suggested measure. The measure information sheet that Workgroups reviewed in preparation for this meeting reflects public information and information from the measure steward as of August 2025. Though, it is important to note that measures may undergo additional updates between now and when the measure specifications for the 2027 Core Sets reporting are finalized. Next slide.

To help Workgroup members review the measure that was suggested, we wanted to recap the criteria for addition. Next slide.

In each meeting, we always come back to our established criteria in three areas for assessing measures. Minimum technical feasibility and appropriateness, actionability, and other considerations. We know that 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 measure discussion. To be considered for the 2027 Core Set, the measure must meet all minimum technical feasibility requirements. Next slide.

On this slide, we show the criteria for addition, starting with the minimum technical feasibility requirements. Starting with these requirements, these requirements help ensure if the measure is placed

on the 2027 1945 Health Home Core Set, states will be able to report on the measure for each of their approved health home programs. First, a measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level. It must have been tested in state Medicaid and/or CHIP programs or currently be in use by one or more Medicaid and/or CHIP programs according to measure specifications.

It must have an available data source that contains all elements needed to calculate the measure, including an identifier for Medicaid beneficiaries. The specifications and data source should allow states to calculate the measure consistently. The measure should also align with current clinical guidelines and/or positive health outcomes. And the measure must include technical specifications, including code sets that are provided free of charge for state use in the Health Home Core Sets. Next slide.

The second category is actionability criteria. Measures that are recommended for addition to the Health Home Core Sets should contribute to estimating the overall national quality of healthcare in Medicaid Health Home Programs and be suitable for performing comparative analysis, should address improving healthcare delivery and outcomes and should enable assessments of program level progress in improving healthcare delivery and outcomes in Medicaid and CHIP.

Finally, other criteria to consider are: Is the prevalence of the condition or outcome being measured sufficient to produce reliable and meaningful results across health home programs? Is the measure aligned with those used in other CMS programs? And will all 1945 Health Home programs be able to produce the measure within two years of the measure being added to the 1945 Medicaid Health Home Core Set? Next slide.

And now with those criteria in mind, I'm going to hand it over to Maria to provide an overview of the voting process and walk through some practice votes.

Maria Dobinick:

Great. Thank you so much, Emily, for walking us through all of that. Voting will take place after the Workgroup discussion and public comment on the measure being reviewed. The voting is open to Workgroup members only. Federal liaisons and other attendees of today's meeting are not eligible to vote on the measure. Workgroup members should let us know through Q&A function in Slido if they will be absent for a portion of the voting.

The measure will be voted on in its currently specified form. For the measure being considered for addition, a yes vote means I recommend adding this measure to the 1945 Medicaid Health Home Core Set. The measure will be recommended for addition if two-thirds of eligible Workgroup members vote yes. Next slide.

So now we're going to go through a couple of practice votes. As a reminder for all attendees, voting for this will be Workgroup members only. So, we're going to take a moment. Emily is going to bring up that voting platform.

Workgroup members, we're asking for you to please make sure that you are logged into your voting account and have navigated to the Health Home Core Sets review voting page if you're not already there. Thanks, Emily. You can use your cell phone and if you don't already have it open, you may use your cell phone and scan the QR code shown in the lower left-hand corner of the screen and go directly to the voting page. As a reminder, if you are not yet logged in, you will need access to the email where you receive correspondence from the health home's team, as you will receive a code from Slido to access the selection where you cast your vote.

We do also suggest that you keep this voting page open for the duration of our meeting today because new voting questions will appear as we make them available. If at any time you don't see the new question, please refresh your page and it should appear. If you need any help, please refer to Section 1 of your voting guide, which we emailed you, or we can send you answers through the chat of the Q&A function in Slido. During voting of the measures, if for any reason you are unable to submit your vote, please send us your vote through the Q&A or to the email address if you are not able to access this. Your votes will be visible only to the Mathematica team.

Okay, so now we are going to do our first practice vote, and it is the age-old question, do you prefer dogs over cats? These options should appear on your voting page, and they should be yes, I prefer dogs, or no, I prefer cats. And we are expecting 10 votes. Thank you to everybody in the audience as we go through these votes, this practice vote. Okay, and we are actually waiting for 11 votes, and we are up to eight.

Again, if any of our Workgroup members are having any issues, please feel to reach out to us through the Slido Q&A feature or via the email. We do ask that all Workgroup members do participate in this practice vote, because then that way, when we get to the real thing, we know everybody is up and running. Okay, we are going to give you one more moment, and then we're going to test out the next question, and we will continue to troubleshoot with you individually. Okay, so Emily, if you can go ahead and close out this vote. Ah, it looks like yes, our Workgroup does prefer dogs over cats, so good to keep in mind.

We are going to do the next practice vote. So, Emily is going to go ahead and bring that up now. And that is, are you right-handed? The options are yes, I am right-handed, or no, I am left-handed. So again, if all of the Workgroup members can go ahead and hop in and give that vote a try. Terrific. We see six of the 11 already. And again, Pamela and Jeannie, if you are able to hop in and get that done, otherwise we're going to reach out to you and do some individual problem solving over the break. Ah, I see 10. All right, Emily, you can go ahead and close that vote and bring it up.

And it looks like we are predominantly a right-handed group here. So, thank you all so much for taking the time to do those practice votes. Again, thank you to our audience members who are so patient as we go through that process to make sure that everything is up and running when we get through to our actual vote. It is currently 11:45. We are going to take a quick 15-minute break so we can go in and make sure our voting platform is ready to roll with our last Workgroup member. And once we return at 12 o'clock promptly, we will begin the discussion of the measure up for votes. So please return and be back here at 12 o'clock on the dot. We will begin the measure discussion at that time. Thanks, everybody. See you soon.

Kalidas Shanti:

Hi, everyone. Welcome back from the break. My name is Kalidas Shanti, and I will talk through the measures suggested for addition to the 2027 1945 Medicaid Health Home Core Set. As a reminder, no measures were suggested for addition to the 2027 1945A Health Home Core Set, and no measures were suggested for removal from the 2027 1945 or 1945A Health Home Core Sets. We can go to the next slide.

The measure that was suggested during the Public Call for Measures is the Adult Immunization Status, AIS. This measure assesses the percentage of members ages 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria, or TD, or tetanus, diphtheria, and acellular pertussis, or TDAP, zoster, pneumococcal, hepatitis B, and coronavirus disease 2019, or COVID-19. The measure steward is the National Committee for Quality Assurance, or NCQA. It is a process measure. The measure is being considered for the 1945 Medicaid Health Home Core Set, and it is an existing measure in the Adult Core Set. The measure is not being recommended to replace a current measure. The data collection method is the Electronic Clinical Data Systems, or ECDS. Next slide.

The measure includes denominators for six rates. Participation is defined as the identifiers and descriptors for each organization's coverage used to define beneficiaries' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. Rate 1 for influenza, members 19 years and older at the start of the measurement period who also meet the criteria for participation minus exclusions. Rate 2 for TD and TDAP is also for members 19 years and older at the start of the measurement period who also meet the criteria for participation minus exclusions.

Rate 3 for zoster is for members 50 years and older at the start of the measurement period who also meet the criteria for participation. Rate 4 is pneumococcal and is for members 65 years and older at the start of the measurement period who also meet the criteria for participation. Rate 5 for hepatitis B and is for members ages 19 to 59 at the start of the measurement period who also meet the criteria for participation. Rate 6 is for COVID-19 and is for members 65 years and older at the start of the measurement period who also meet the criteria for participation. Next slide.

The measure includes numerators for six individual rates. This slide and the next show the criteria for numerator compliance for each of the six vaccine rates, including time period when the vaccine must occur and any contraindications that should be considered. And I'll wait a moment if people want to briefly look through the numerators. Okay, next slide.

This slide shows the numerator criteria for the final two vaccine types in the measure. And I'll allow for a little bit of time here as well. Okay, next slide.

The current technical specifications for this measure allow for stratification. The individual who suggested the measure noted disease prevention is important for all populations and is very important for Medicaid health home enrollees to reduce the risk of being diagnosed with a vaccine preventable condition. The suggester added that over the last few years, the United States has experienced increased prevalence of individuals that are either non-vaccinated or not fully vaccinated being exposed to and diagnosed with vaccine-preventable conditions.

They went on to add that individuals enrolled in the health home programs are qualified due to their health status of two or more chronic conditions, have one chronic condition or are at risk for another chronic condition, or having one serious and persistent mental health condition, including substance use disorder. The individual who suggested the measure indicated that contracting a vaccine-preventable condition would increase the complexity of their needs and care, and they increase the potential for serious adverse outcomes.

This also suggests that the measure noted is included—sorry. The individual who suggested the measure noted this measure is included as NCQA Medicaid HEDIS measure. They added that in measurement year 2023, the most recent data available of the 270 Medicaid plans reporting HEDIS measures that were validated by NCQA certified HEDIS compliance auditor, 238 submissions, or 85.6 percent, reported this measure. The individual who suggested the measure noted the measure can be trended over time. They added that the stratification of the measure may also identify quality improvement initiatives to increase adult immunization rates.

Care measures providers and the Medicaid Health Home Program, with their direct interaction with health home members, have opportunities to influence and encourage members to receive adult immunizations. And now I'll hand this back to Maria to facilitate our Workgroup discussion of the Adult Immunization Status, or AIS measure.

Maria Dobinick:

Thanks so much, Kalidas. Next slide, please. As a reminder to the Workgroup members and federal liaisons, you may raise your hand, and we will call on you on the order in which your hand was raised. You may unmute your line after we call on you. Please remember to say both your first and last name before making your comment. And we'll begin our discussion. So, if anybody would like to begin the discussion. Jeannie, I see your hand raised. You can go ahead and unmute yourself.

Jeannie Wigglesworth:

This is Jeannie Wigglesworth from Connecticut. We actually have our medical Medicaid ASO that already completes this measure. But my question more is the—I thought I saw there was a nine-year look-back. And the COL measure, Colorectal Cancer Screening, also has a nine-year look-back for one of its screening. And I don't know about other people, but in Connecticut, we're only saving like three or four years of claims. So, it's a little bit more difficult for us to do that look-back for nine years. I don't know if anyone else has that same issue or not.

Maria Dobinick:

Thank you for your question. I believe we do have somebody from NCQA on the line. If there is a measure expert here who is able to answer that, if you can raise your hand. I believe, Gabby, I see you. You should be able to unmute yourself.

Gabby Kyle-Lion:

Yes. I am. Are you able to hear me, okay?

Maria Dobinick:

We can hear you perfectly.

Gabby Kyle-Lion:

Okay. Great. So sorry, the question was around the nine-year look-back period in the TD/TDAP rate. Is that correct?

Maria Dobinick:

Yes. Yes.

Gabby Kyle-Lion:

So, there is one in there. There is a nine-year look-back period in there. And as far as plans having trouble looking back that far, we've heard that previously. It's something that we're thinking about and considering, but the recommendations for the reason it's specified that way is because the look-back or the recommendations for TD/TDAP are one TD/TDAP vaccine within 10 years. So, you know, that's the reason it's functionally specified that way. But I do acknowledge that there are concerns about finding that data from nine years previous. You are able to use—I know that the immunization registry data might be difficult to find. But there also is the ability to use EHR data in this as well. So, you know, if providers are documenting vaccine history, you are able to use that as a data source as well.

Jeannie Wigglesworth:

Okay, great. Thanks. We just, in Connecticut, came up against the same issue with COL. So, I was just curious how you were—I mean, we just look back as far as we can and we still submit the measure. But thank you.

Gabby Kyle-Lion:

Yep.

Maria Dobinick:

Thank you both for that. Janelle, I see your hand raised. You may unmute yourself.

Janelle White:

Thank you. Yep. Just wanted to also agree about the challenges with the nine-year look-back. So, you know, again just, sounds like Connecticut. I would just co-sign for North Carolina as well.

Maria Dobinick:

Thank you for that, Janelle. Anybody else have questions? Oh, it was erased. Jeff, I think I saw your raised hand first and then Ari, we will go to you. Jeff, you can unmute yourself.

Jeff Schiff:

Thanks. I just wanted to ask the NCQA measure steward about the—because it seems that this has been in a discussion recently, the COVID rate is for folks over 65 to get a booster. And I don't know what the

considerations were for adults 18 to 64. And then along those same lines with this measure, most folks over 65 end up in Medicare. And is there a data problem related to getting that data? The folks over 65 in Medicaid, I think, would mostly be folks who are duals.

Maria Dobinick:

Gabby, if you'd like, you may unmute yourself to answer.

Gabby Kyle-Lion:

Yeah, sure. Thank you for that question. So, I'll answer the first question first about if there was consideration for those younger than 65. And there was. When we originally tested this measure, we actually did test it as a 19 and older measure. But there was some concern from our experts that we consult with as we develop measures about changing guidelines. And so, as well as signals from ACIP, the Advisory Committee on Immunization Practices, on how they're considering changing their recommendations, we limited the rate to 65 and older.

And then, as far as this is a rate for Medicaid, Medicare is mostly the 65 and older, and how it applies to Medicaid. So, this measure, this was newly added for measurement year 2026. So, I actually don't have data to share about the ability for Medicaid plans to report at this point in time. But I can certainly, you know, share that at a future meeting once we do have that data. I will say that all of the indicators are reported in commercial Medicare and Medicaid. And, you know, at this point in time, we have seen a report of a fair number of Medicaid plans able to report on all of the indicators, including pneumococcal, which is a 65 and older measure as well.

Jeff Schiff:

Thank you.

Maria Dobinick:

Thank you so much, Jeff and Gabby. Ari, you're next. And then, Kim, I also see your hand. You can go after Ari.

Ari Houser:

Yeah. Jeff actually beat me to my question in the race. It was also about the COVID-19 age range. And that really jumped out at me because it was the one disconnect of this measure with, as far as I can tell, the current recommended immunization schedule updated last month on the CDC website, which still recommends annual COVID-19 vaccination for all adults. And to me, it's particularly critical for this population because this population is primarily non-elderly adults with complex health needs that means additional risk factors.

And if I looked at all of these diseases and what I would be worried about, for health home enrollees, health effects, it would, without question, be COVID-19 for ages 19 to 64. And so, I feel like it's kind of like playing the Yankees without Aaron Judge. They're not a bad team, but it's missing the biggest piece. I don't think this would change how I would vote on the measure, but it is—the biggest possible gap is the one gap that we see.

Maria Dobinick:

Thank you for that comment, Ari. Kim?

Kim Elliott:

Hi, thank you. Yes, I like this measure for quite a few different reasons. But one of the things that when I look at the core measure set overall is it doesn't really have a lot of measures on the preventive health side and somewhat even on the well side. And I think that this would be a real benefit to add something like this to keep the individuals being served through the health home program in more of an optimal position from a health perspective. And that's just my thought.

Maria Dobinick:

Thank you for your comment, Kim. I don't see any other hands raised. We will have an opportunity for a public comment in a moment. I just want to keep the floor open for Workgroup members if they have additional questions specifically for NCQA, the measure steward, or comments they would like to make about the measure. Clarissa, I do see your hand raised. You may unmute yourself.

Clarissa Barnes:

Hi, this is Clarissa Barnes from South Dakota. I know that like a couple of minutes ago when there was concerns about sort of the ability to capture the data for some of these immunizations, especially in like the dual eligible, the response was that other states have been able to do it. Is there any information on sort of the technical sort of aspect of sort of how they're able to capture that? Because, you know, realistically, we are leaning heavily on claims data. And if we are not getting claims data, it is difficult for us to sort of pull out. We don't have access right now really to EMRs directly. And we certainly, you know, if you're billing, you know what I mean? Like it would be nice to sort of get a little bit more information about sort of how they were able to achieve that.

Maria Dobinick:

Thank you for that question. Gabby, is that something that you are able to answer?

Gabby Kyle-Lion:

I think I can try to answer that. So, Clarissa, thank you for that question. I don't have specific—we haven't had specific conversations with Medicaid plans in particular about how they have reported this measure. But when plans report to HEDIS, as I'm sure you all may be aware, we have asked in the past for the reporting category, the SSOR, which lets us know what data source they use. And across all three product lines, the majority of submissions use data from immunization registries and electronic health records. They have increasingly relied less on claims data or case management very rarely. I don't know that that answers or is a good answer to your question, but that's kind of the only information I have around, you know, how plans are reporting this measure, in particular Medicaid plans.

Maria Dobinick:

Thank you, Gabby. Demi, I want to acknowledge your hand, but I also just want to say, are there any other state Workgroup members who might have experience with this related to Clarissa's question? Demi, I'm not sure if that is why you have your hand raised or not. If so, you can take yourself off mute and answer.

Demi Culianos:

Yeah, that was why I had my hand raised. So, this is Demi Culianos from New York State. The way that we access data for this is through immunization registries. New York State actually has two registries, one for New York City and one for the rest of the state. So, we typically don't use claims, but there are issues with linking that data from the registries to other data sources. So, there is like, oh, it's going to be issues with undercounting, but our electronic sources are improving. So, I think it's really a question of how valid the rates are using these two different data sources.

Maria Dobinick:

That was really helpful. Thank you. Jeff, I see your hand up. You can unmute yourself.

Jeff Schiff:

I just wanted to ask a follow-up question for New York. Do you then link individual patient-level data in these registries to Medicaid enrollment in order to make this measure valid for our population?

Demi Culianos:

Yeah, that's a great question. So, it is a little bit complicated in that the New York City registry is much more advanced than the rest of the state's registry. So that is easier to access. And the plans actually work with a different department within the Department of Health to access that data. So, they will send patient-level file or member IDs to the registries and be able to get that data from the Department of Health, and then they submit that plan data to us.

Jeff Schiff:

Thanks.

Maria Dobinick:

Thank you both for that. Jeff and Demi, I see your hands are both still up. If you can lower them. Any other Workgroup members with questions, comments, experience collecting this or comparable measures?

Okay. Thank you all for that really robust discussion. Next slide, please.

Now we'd like to provide an opportunity for public comment on the Adult Immunization Status or AIS measure. Please use the Raise Hand feature in the bottom right of the participant panel to join the queue and lower your hand when you are done. I will let you know when you've been unmuted. Also, if you can please introduce yourself and your affiliation before any comments.

Again, if you would like to make a public comment, you may use the Raise Hand feature. And this is an opportunity for comments or questions to the measure steward by the public. Okay. I am not seeing any. I

will open it back up one last time for Workgroup members before we go into our vote on this measure. Any last questions or comments from the Workgroup before we vote on the measure? Okay. I am not seeing anybody. Next slide, please.

And now it is time for our vote. Emily, if you could bring up our Slido. The question is, should the Adult Immunization Status AIS measure be added to the 2027 1945 Health Home Core Set? The options are yes, I recommend adding the measure to the Core Set, or no, I do not recommend adding the measure to the Core Set. Voting is now open. If the question does not appear on your voting page, please refresh your web browser. Also, if you have any questions as we are going through, please email us or send us a question in Slido. Thank you for your patience. I have one vote remaining. And I think it just came in.

So, give us one moment. Thank you all. We will have the vote in just one moment. Okay, Emily, we have all of our votes if you could please close our voting. Okay, we have our vote in. And we have a vote of nine yes and two no's, and that does meet the threshold for recommending this measure to the 2027 1945 Health Home Core Set. Thank you to our Workgroup members. Emily, you can close the voting. All right, and next slide, please. Next slide. Perfect.

Thanks, everybody, so much, and thank you for the time and research and discussion that went into that vote. Right now, we're going to shift gears and start to look ahead to future Core Sets. Next slide, please.

As many of you know, each year the Workgroup discusses measure gaps on the Health Home Core Sets, and the gaps conversation from the prior Workgroup discussion informs the call for measures for the subsequent annual reviews. This annual review cycle was the first time that we had a Public Call for Measures, and the Workgroup's identified gaps were presented as part of the orientation meeting, and as we discussed this year's gaps, we will do the same next year. After our Workgroup discussion on gaps, we will have another opportunity for public comments. Next slide.

So how are we going to do this? First, we'd like all of the Workgroup members to think about priority gap areas in the current Health Home Core Sets, that's both 1945 and 1945A, that could be addressed by the Public Call for Measures to strengthen and improve the Core Sets. We know that over the years we've had a lot of conversations and some questions about measures that were related to particular topics and themes.

But we want to always keep in mind, and Jeff mentioned this, that the purpose and use of the Health Home Core Set is to estimate and understand the overall national quality of healthcare provided in the Medicaid Health Home Programs, to assess the access to and the quality of the healthcare provided to the beneficiaries, and to use this Core Set data to develop quality improvement efforts. One consideration the Workgroup has raised in the past is really related to the health home program enrollment and the specialization across the variety of programs.

As a quick reminder, 1945 Health Home Program enrollment can target specific conditions and geography, but not age, delivery system, or dual eligibility status. 1945A Health Home Program enrollment is eligibility focused, right? And states established that eligibility highlighted in a previous slide, rather than limiting it to a specific condition or geography. So, this year, we really want the

Workgroup to think about both general gaps as we measure opportunities to encompass this range of complex and chronic conditions that are represented across the enrollee population, and we want you to think about a few questions.

For example, would adding measures targeting specific organ systems be of any help in strengthen or improve the Medicaid Health Home Core Sets? I want you to remember we're not asking you to identify a particular measure here today, right? Rather, we really want to discuss these concepts and areas of potential that could help inform the 2028 Public Call for Measures. We'd also like to be sure we hear from all Workgroup members about these gap areas. So, we're going to do a lightning round. We're going to use the order of the roster from the roll call and ask each Workgroup member to mention one priority gap area or plus one something that another Workgroup member has already mentioned. So, let's get started. Kim, let's kick it off with you.

Kim Elliott:

Wonderful. I did put a lot of thought into this after we received the email that indicated we'd focus on different body systems. And one of the things that came to mind for me really is the cardiac or circulatory system. And the reason I think about that when I think about the Health Home Core Set are the conditions that make you eligible for the health home in and of itself. So not only the conditions themselves, but also a lot of the treatment and medications, they do have impacts on your heart and on your circulatory or cardiac system. So, that's one gap area that I think would be a benefit to focus on for consideration of gaps.

Maria Dobinick:

Great. Thank you so much, Kim. Jeff, let's hop to you.

Jeff Schiff:

Thanks. I want to talk just a little bit about something that I think most of us who are engaged in this are aware of, and that's that we don't have CAHPS on the Health Home Core Set. And I think that that's really sort of a reflection of how hard it is to collect that data. And I think when I think about this, I think about, you know, that data is hard to collect, and the data is mostly about patient experience of care. But some patient experience of care, I think we somehow need to get to. And I'm just going to point to two things.

One is that families or the patients are partners in the care. And I think that when we break down some of the CAHPS, I think that's something that's pretty essential. And then whether or not patients feel like they have access to the services they need. So, I'm going to highlight that as one specific thing. It's not organ system specific. But while I'm not on mute, I'm going to add one other thing. I agree with Kim. I think one of the other things we might want to consider is hemoglobin A1C control because of the prevalence of diabetes in the population. We have obesity and BMI in here, and we also have blood pressure, but that may be also worth considering. Thanks.

Maria Dobinick:

Great. Thanks to you and Kim both for your really thoughtful insights there. So now we're going to start going down to the list. And Ari, we will start with you. You may unmute yourself.

Ari Houser:

Ari Houser. As I look at the Core Set, I think, to me, the biggest gap in terms of health impact that the Core Set doesn't currently address is a measure of diabetes management or screening. We narrowly voted not to include such a measure last year. And I think that still remains the single largest gap that I could see in the Core Set.

Maria Dobinick:

Thank you so much for that, Ari. Clarissa, you're next. You can unmute yourself.

Clarissa Barnes:

I don't know if this is a case of, like, great minds think alike or not, but my first thought in terms of, like, gaps really did go to metabolic health as well with regards to sort of diabetes, whether it's control of already identified diabetics or screening and identification of people who maybe are not diagnosed. And that was sort of my traditional thought. I will throw out there that, you know, thinking very, very broadly, I don't know, like, since we're not being asked to sort of submit measure details, this is just sort of wishful thinking.

It would be nice in this current healthcare climate to be able to get a better sense of sort of the, for lack of a better word, trust that recipients have or patients have in the care that they're being given. Which sort of ties a little bit in with access but also sort of that relationship because we know that so many of these things only really move forward if they have a good relationship with that primary care person who's taking care of them. I have no idea what that measure would look like, but it would be nice to be able to get a sense of, you know, or rewarding people for, like, if you have a good relationship and they trust what you're saying, like, hey, that's half the battle, you know, for all of these other actual healthcare measures.

Maria Dobinick:

Yeah, thank you for that, Clarissa. And yes, just wanted to reinforce, we're not here to identify a measure today. So, your observations about gaps and hopes for the future is exactly the right direction that we want to go in. So, I appreciate that. Demi, you're next.

Demi Culianos:

Sorry, I was double muted. So, echoing what everyone else has kind of already mentioned, I think it would be worthwhile to have some kind of measure looking at diabetes outcomes or cardiovascular disease. It is something that we examine as part of our evaluation for health homes, and I think it would be worthwhile to have something like that on the Core Set.

Maria Dobinick:

Great. Thank you so much for your insights. Janelle, you're next. You may unmute yourself.

Janelle White:

Thank you. Agree with everyone. I think we're sort of singing from the same sheet of music here, looking at the cardiometabolic conditions that, you know, we see in general population and then also specifically for this population as well. I also would like to co-sign Clarissa's comment about the trust in the care team in North Carolina, that is, for our LTSS services, one of the metrics that we monitor for our private duty nursing and community alternative program population. So, sort of see a one in the same here. Thank you.

Maria Dobinick:

Thank you, Janelle. Jeannie, you may unmute yourself.

Jeannie Wigglesworth:

There. Excuse me. This is Jeannie from Connecticut. So again, I agree with the metabolic syndrome. And looking at the current measures that we have, we do look at a lot of higher level of care usage, right, and follow up after, but not as much as for preventative care. So, in Connecticut, we're kind of blessed because we work with our sister ASO Medicaid company that does the medical side of things. And they will send us information regarding, you know, maybe who is on a medication that may raise their A1C or, you know, who has been diagnosed with diabetes and still needs their screens. Or who is on an asthma medication and still, you know, is not really being compliant with it.

Those type of things have been incredibly helpful for our team to help encourage and, you know, remind our enrollees and work also collaboratively with the doctors. Because in it, it will say the main PCP across the board. And in Connecticut, we focus on the SMI population and coordinating with medical providers, just to put context in it. So, anything regarding preventative screening, I think, would be great because our goal is to try to stop before they get to the diabetes and, you know, all the other higher levels of care that are associated with it.

Maria Dobinick:

Thanks, Jeannie. And I really appreciate you taking a few moments to give that specific example and those insights on how you're doing things in Connecticut and how you feel like this is a movable metric, right? I think that something else, right, that as a Workgroup we really think about is what we're adding something that's actionable by our health home providers. And so, thanks for providing an example of that.

Jeannie Wigglesworth:

Sure.

Maria Dobinick:

Great. Johnny, you are next. You may unmute yourself.

Johnny Shults:

Thanks for the opportunity to share. I don't know that I can add too much more other than to express that we understand the direction that folks are proposing and certainly agree with the direction they're setting. We also, at the state of Washington, are focusing in on behavioral health treatment as well. So that is a direction that we are considering as we are looking at our measures.

Maria Dobinick:

Great. Thanks so much. Laura, you are next. You may unmute yourself.

Laura Vegas:

Thank you. This is Laura. And kind of following along to what Johnny said, we do have some measures in there about, you know, supporting mental health, supporting good mental health. But it's maybe focusing more on the preventative piece of that, screenings, looking at issues of polypharmacy and what those mean for people. So, the preventative side, how to keep people out of crisis and out of hospital settings by the healthcare that they receive.

And I think I say this every year too, and I actually looked around for some measures to recommend, but I think it's important to see some measures around the care coordination or the coordination piece of the home health model. And the work that I've done in the LTSS space, those people are like the linchpins of good quality care. And you might could say, well, we could see evidence of good quality coordination in the health outcomes for people. But I think it's important to really look at the care coordination in and of itself. Thank you.

Maria Dobinick:

Yeah. Thank you for that. I appreciate that. Macy, you are up next.

Macy Daly:

Hi, everyone. I don't have a lot to add. I know everybody's made some really excellent points. I guess just coming from a behavioral health background, and I believe this may be a retired measure, but just thinking about tobacco use and its prevalence among folks with behavioral health conditions and the fact that it impacts other chronic diseases like diabetes, COPD, cardiovascular system. So, I think that that could be an interesting thing to reexamine is, you know, smoking and smoking cessation efforts.

Maria Dobinick:

Thank you so much, Macy. And I just want to repeat what you said, because at least on my end, you broke up a little bit. So, what I heard was a focus specifically on cardio and respiratory, specifically by way of that tobacco measure. Correct?

Macy Daly:

Yes. Thank you.

Maria Dobinick:

Perfect. Thanks for allowing me to repeat that back to you. Okay. And last, we have Pam Lester. Pam, you may go ahead and unmute yourself.

Pam Lester:

Hello. Thank you. I would like to see us focus on dental health—dental health and dental health measures, ensuring that they're coordinating and getting them in to see a dentist, ensuring preventative care or getting in early to address any issues. And our state might be a little unique in that we have for Medicaid, we do have dental plans, but it's something that we see is a struggle for folks getting in to see. And it does affect what they eat and other things. So that's something that I would like us to look at.

Maria Dobinick:

Yeah, Pam, thanks so much for raising that. And also, for flagging the dental is more than just the teeth. Right? That there is also the potential that that could impact the nutrition aspect and what people are able to consume, their intake and making sure that they're generally healthy overall. So really appreciate that. I want to open it back up to the Workgroup in general in case there was anything one of your fellow Workgroup members said that really particularly pinged for you, especially as related to organ systems, and also remembering that we have both 1945 and 1945A which is that program for children with medically complex conditions. Kim, I see your hand up. You may unmute yourself.

Kim Elliott:

When I did my first one, I really did want to focus on the organ system since that was kind of what we were focusing on during this call. But I do think from a gap perspective, I agree with, I think there were two other members that brought these up. The well-care preventive healthcare, because individuals with chronic health conditions experience really ongoing challenges related to the care needs for their conditions. And this sometimes results in the well-care preventive healthcare taking a little bit of a backseat from a healthcare foundation level.

Ensuring ongoing routine preventive care, it really does provide an opportunity for individuals to maintain their overall health and support the care and needs related to their chronic conditions as well. So again, I stated it before when I talked about the cardiovascular, but maintaining optimal health for each individual served in the health home program provides opportunities for the achievement of their individual goals and objectives that are in their person-centered care plan, which is also kind of a key component of health homes. So, therefore, potentially having a more positive impact on the individual's quality of life.

And with that, I tried at least in my thought process, several different things such as the access to care measures like adult access to care. We just talked about and voted about the immunizations, the cholesterol screening, all of those things kind of tied to that optimal health so that they have the best opportunities to be successful in managing the chronic diseases as well. And I also agreed with the care coordination and case management. I know a few Workgroups ago, we did have a measure that we discussed. It wasn't ready for prime time yet, but care coordination and care management. And the health home program, you know, members are assigned or have access to care coordinators and case managers.

And these care coordinators, of course, and the person-centered care plan play key components in really achieving those optimal health outcomes for each of the individuals. So, measures or measures that evaluate the ability or access to care management, the effectiveness of care management, the completeness, maybe, and the use of person-centered care planning and assisting members receiving the preventive health, the well care, and the recommended care for their chronic condition or mental health conditions. I think that would potentially impact or improve the results and the other measures that are included in the care set. So, I think, overall, that would have a really big impact. And I think it is kind of a gap in what we're currently looking at or have included in the Core Set.

Maria Dobinick:

Thanks so much for those additional comments, Kim. Last call for Workgroup members for comments related to gaps on the Core Set. Jeff, go ahead.

Jeff Schiff:

I wanted to—this is a follow up of what Kim just said and then what Janelle and Laura said as well. Janelle, you talked about trust in the care team. I've certainly had the experience in Minnesota where we had really good control of hemoglobin A1C at clinics with, I would say, a population that had other challenges because of some of the things that were set up and some of the trust in the care team was pretty essential to that.

And then, Laura, you also mentioned measures around care coordination because the care coordinator is really the linchpin of this. And, Janelle, I'm just curious if you want to say anything specifically about how or if you measure that. And, Laura, I think yours was more of an aspirational thing to measure that. But I just want to hear about any more detail that exists right now and where you guys are.

Maria Dobinick:

Thanks for that, Jeff. If either of you want to go ahead and off mute and answer that, that's terrific. Janelle, I see you're off mute.

Janelle White:

Yes, I am happy to, Jeff. Thank you for highlighting that and double-clicking on what I mentioned. We have an annual quality report that we do at North Carolina Medicaid. And part of that, you know, part of our measures, metrics that we report out on, again, for our LTSS, long-term services and supports, part of the CAHPS survey includes the trust in the care team. And we've seen, thankfully, incremental improvements.

So again, I think that's important for a number of reasons that we've highlighted here, right, that may, again, result in the improved outcomes. Another aspect of that for me that I wasn't necessarily going to lift up, you know, because, again, I'm not sure. It may be a bit out of scope, but since, you know, I was asked, I will elaborate a bit more. But here in the state with the recent Hurricane Helene, for me, the outreach that was needed, right, you know, for—these are very vulnerable members. So, I think just having that trust in the care team will help with some of those responses to recovery efforts. And then

also, as was lifted up, the care coordination, again, that is very important. I was going to double-click on that one as well.

For me, thinking of, like, disaster response and recovery, again, something that we thankfully don't encounter often, but when it matters, it matters. And if anyone is interested in the trust in the care team, you know, I'm happy to share our annual quality report where it talks through some of the measures related to that that we monitor annually at Medicaid in North Carolina.

Jeff Schiff:

Now, can I just ask a follow-up? Can I just ask a follow-up?

Maria Dobinick:

Absolutely. Absolutely, Jeff. Go ahead.

Jeff Schiff:

Is that report exclusively for LTSS folks?

Janelle White:

No, the report is our overall quality strategy, so LTSS is one population that we highlight in the strategy. But it's our overall quality report.

Jeff Schiff:

Okay. Thanks.

Maria Dobinick:

Thank you so much. All right. Last call for my Workgroup members, and then we're going to open it up to the public. All right. Next slide, please.

Do any Workgroup members have any comments related to gaps on the Core Set measures? If so, please raise your hand, and we will call on you to be unmuted. Okay. I'm not seeing anything from the public. We'll have one more opportunity for public comment before the end. Thank you all.

So here we are. Let's have a really quick recap of the Workgroup's recommendations for updating the 2027 1945 Health Home Core Set. The Workgroup considered one measure for addition to the 1945 Health Home Core Set. No measures were considered for the 1945A Health Home Core Set. As a reminder to be recommended for addition, a measure required a yes vote from at least two-thirds of the Workgroup members. And we thank everybody for managing the voting technology in this virtual environment. The Workgroup did vote to recommend the Adult Immunization Status, or AIS, measure to the 2027 1945 Health Home Core Set. Reflecting on the Workgroup's discussion today, there were considerable discussion topics around three criteria, specifically feasibility and actionability. And I specifically want to thank the Workgroup for their really thoughtful technical questions, and for NCQA being able to answer them related to data required to collect and report on this measure.

So now we're going to continue to think about the future directions of the Core Set. And we, again, want to open it up to the Workgroup members and hear your special thoughts on two topics. First, are there additional needs that will help support the identification of measures to fill those gaps that we just discussed? For example, are there additional measure testing that needs to happen? Or are there needs for opportunities in technology and ECDS to reduce some of that collection burden that we heard some states talk about?

I heard some Workgroup members even mention previous conversations and previous measures that may have felt too burdensome in the past, and that's not why they were suggested for recommendation at that time. So, these are the sort of things and needs that I'm going to open it up for public Workgroup comment on right now. Any Workgroup members? Jeannie, I think I saw your hand first. Go ahead.

Jeannie Wigglesworth:

Hi. Yes. So, as we're all kind of moving toward the electronic measures, and forgive me if you might have offered it in the past and I missed it, but just a Workgroup around that and what does that mean, and especially trying to move towards the supplemental data more. You know, there's a lot of language in the specs of non-standard supplemental, standard supplemental, and the different chart reviews and everything you need to do as a result of that. And I just think it's a lot to navigate, and it probably would be beneficial to just have like an overview of the steps for that when you're, you know, thinking of moving in that direction.

And the other thing I just, I said it last time, was just to be able to benchmark. For the adult core and the child core, it's pretty simple to benchmark, but for the health homes it's kind of hard, because every state is kind of varied in the population that they're serving and, you know, who's included, CHIP, Medicaid. And so, it's a little hard for me to see or to benchmark Connecticut specifically, and I didn't know if there was any recommendations around that.

Maria Dobinick:

Great. Thank you for that. And specifically, are you looking to benchmark across other like programs?

Jeannie Wigglesworth:

Yeah. Go ahead.

Maria Dobinick:

So serious mental illness health homes against other serious mental illness health homes, as well as, like, even if another state does not necessarily have that same health home type, would you also still be interested in kind of comparing yourself for comparable states?

Jeannie Wigglesworth:

Yeah. Like, and others, like, we currently do not report duals, but many do. And so that, again, is a little hard to compare as well. And I don't even know if it's possible, but I don't know. But if we can group them or something, I don't know, that would be beneficial on my end, on our end in Connecticut.

Maria Dobinick:

Yeah, absolutely. Thank you for raising that. And we're always trying to think of new ways to talk about the public reporting and do it in a way that's helpful for the state to make that data usable. So, thanks so much for raising that. Kim, go ahead. You're next.

Kim Elliott:

I think one of the continual challenges that we have for health homes is that many of the measures that are available to—that would meet the criteria, really focus not so much on the populations included in the health home population, but a much broader range. So, I don't know that—I think it just makes it a bit more challenging. And I'd like to see maybe a little bit more development in the area of the special needs populations. It just is a little bit different than when you're measuring and comparing against the entire Medicaid population.

Maria Dobinick:

Yeah, thank you for highlighting that. Any other particular needs or wishes related to future measures that we might want to test, electronic needs? Are there opportunities to use electronic data in new ways or different ways? Are there ways that health homes already reporting data in some of these electronic systems that we might be able to capitalize on there? Jeff, I see your hand is up.

Jeff Schiff:

I'm kind of fascinated by some of the electronic data reporting issues, but my comment is a little bit more about stratification because the health home program lies on top of some pretty big national efforts, you know, in CMS, around value-based care. And I really, I guess it's more of a comment that I don't know if we're ready to address in this group or maybe just to pass on to CMS, but maybe some stratification around the impact of value-based care on some of these outcomes may be worthwhile. It kind of lies on top of the reimbursement mechanisms we already have.

Maria Dobinick:

Yeah, thank you for that. So related to the value-based care and reimbursement as areas to understand. Thanks for that. Anybody else? Thank you for all of those comments. Really, really thoughtful. Jeannie, I see your hand up. Is that a continuation of your previous comment or a new comment?

Jeannie Wigglesworth:

I'm sorry. I just have one more thing.

Maria Dobinick:

Absolutely.

Jeannie Wigglesworth:

For those who don't have vendors to program their measures, we do have a vendor that does the HEDIS Core Set, but not the CMS, and we do program those in-house. It's never been clear to me, like, a format or a forum that we can go to when we have questions about the interpretation of some of these

measures, because sometimes they're not so easy to interpret, and people may, you know, interpret them differently in how they program them. So, I was just curious if there was a place we could go to ask questions about that when we're programming.

Maria Dobinick:

Yeah, I think you can always reach out to the TA mailbox in general, and folks can help you there as they are able through both the programming side, if that's something that they have insights on, as well as how to interpret what you are seeing. So, there is the reporting TA mailbox, and I would point you in the direction of that.

Jeannie Wigglesworth:

Okay. Thank you.

Maria Dobinick:

Yeah. Perfect. So, I want to take a moment, if we don't have any other comments related on that, to also think about technical assistance. And we already started to sort of dip our toe into that with Jeannie, your comment about workgroups, or maybe understanding some of the definitions around supplemental data. So, thinking about the measure that was just voted on and the current Core Set, both the 1945 and the 1945A, are there additional areas of technical assistance, suggestions on how to build state capacity for calculating and reporting the Health Home Core Set measures? And again, please raise your hand and we'll call on you.

All right. I am not seeing any additional TA suggestions. And last but not least, in the spirit of continuous quality improvement, I'd like to take a moment to give the Workgroup members an opportunity to suggest ways that we might improve this annual review process for next year. So please raise your hands and let us know. All right. I am not seeing any hands raised. All right. Next slide.

I'd now like to provide one last opportunity for public comment. If you would like to make a comment, please use that Raise Hand feature in the bottom right of the participant panel to join the queue, and lower your hand when you are done. I'll call on you and let you know when you've been unmuted.

I do see Sara Rhoades. You have your hand up? If we could unmute Sara and give her an opportunity to make a comment. Hi, Sara. We can hear you.

Sara Rhoades:

Hi. I just wanted to mention one thing to this group, just during the discussion. This is Sara Rhoades. I'm the technical director for health homes. And while I appreciate everyone being part of this, while I was listening in, I just wanted to mention one thing. I heard someone mention about the value-based incentives and things that are going on. And I just wanted to kind of let this group know that the Innovation Center, there's some different models and things. And we have been working closely with health homes model on some of the innovations around that kind of work and the quality component as well as the payment component to that. So just kind of a heads-up that, as you're thinking, next year as the Workgroup reconvenes.

Maria Dobinick:

Thank you. Last call for public comment. This is the last opportunity today for a public comment. Okay. Thanks, everybody.

So, as we wrap up, I'd like to take a few moments to outline our next steps. First, we're going to review and synthesize today's discussion and prepare a draft report. We're anticipating that we will make the draft report available for public comment in November. Workgroup members and the public will both have an opportunity to review and comment on the report, and we expect to release the final report in February of 2026. From there, CMS will obtain additional input from interested parties, including other federal agencies, and will make final determinations for the 2027 Medicaid Health Home Core Sets. If anyone has any questions from our team about the content of this meeting or the annual review process, please email our team at Mathematica at the email address shown on this slide. Next slide.

And finally, one last big thank you to our Workgroup members, federal liaisons, our measure steward, and public attendees all for your contributions. We want to express deep appreciation to the staff in the Medicaid benefits and health programs group and the Division of Quality and Health Outcomes at CMCS for your support. And, of course, a special shout-out to this Mathematica Health Home Core Sets team. This meeting could not have been possible without everybody's help.