2026 Medicaid Health Home Core Sets Annual Review:
Meeting to Review Measures for the 2026 Health Home Core Sets Day 1 Transcript
June 25, 2024, 11:00 a.m.- 2:30 p.m. ET

Maria Dobinick:

Hi, everyone, my name is Maria Dobinick, and I am pleased to welcome you to the first day of the Medicaid Health Home Core Sets Annual Review Meeting to review measures for the 2026 Health Home Core Sets. Before we get started today, we wanted to cover a few technical instructions. Next slide. If you have any technical issues during today's webinar, please send a message to all panelists through the Q&A function located on the bottom right corner of your screen. If you're having issues speaking during the Workgroup or public comment section, please make sure you are also not double muted on your headset or phone. Connecting to the audio using your computer audio or the Call Me feature in WebEx are the most reliable options. Please note that call in only users cannot make comments. So, if you wish to make a comment, please be sure that your audio is associated with your name in the meeting platform. Next slide.

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 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 be unmuted in the order in which your hand was raised. So please wait for your queue to speak and then remember to lower your hand when you have finished speaking by following the same process you use to raise your hand. Note that chat is disabled for this webinar, so please use the Q&A feature if you need support. 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'm going to hand it over to Tricia Rowan to get us started.

Patricia Rowan:

Great. Thanks, Maria. Next slide. So, hi everyone, it's Tricia Rowan. I'm a principal researcher at Mathematica and a senior consultant for Mathematica's Technical Assistance and Analytics 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 2026 Annual Review of the Medicaid Health Home Core Sets. Thank you to our Workgroup members, our federal colleagues and members of the public for joining us for this virtual meeting. Next slide.

I want to take a moment to acknowledge my colleagues at Mathematica who are listed here on the slide. This really has been a team effort to prepare for the meeting, both in terms of content and the logistics. It is also our fourth year doing this review. And so the team is just critical to pulling this off every year. I also want to acknowledge our colleagues at Aurrera Health Group who will be helping write the report summarizing Workgroup discussion and recommendations. Next slide.

All right, so we have a full agenda and many important objectives to accomplish today and tomorrow. The meeting objectives are listed here on the slide. Let me go over them quickly. So first, the Workgroup will discuss three measures that were suggested for addition to the Medicaid Health Home Core Sets. Second, the Workgroup will vote on those measure suggestions. Third, the Workgroup will discuss priority gap areas in the Health Home Core Sets and criteria for the 2027 public call for measures. This discussion will take place on the second day of the meeting and before we wrap up today, I'll give you a little preview of what our plan is

for that discussion. And as always, we will provide multiple opportunities for public comment both today and tomorrow to inform the Workgroup's discussion.

As you may have noticed, we have a shorter agenda for tomorrow. We expect to end both days around 2:30 PM rather than 4:00 PM as originally planned, so hope you enjoy a little extra time in your afternoon. I'd also like to pause for a moment and note that Mathematica is committed to a robust, rigorous, and transparent meeting process despite the virtual format. That said, we acknowledge that attendees may sometimes experience challenges with a virtual meeting format, and I hope everyone will be patient with us as we do our best to adhere to the agenda and fulfill the objectives of the meeting. Some of you may also be wondering why we tend to not to use video for these meetings. We've mentioned this previously, but in the past, we've had issues where individuals or some locations don't have sufficient internet or Wi-Fi bandwidth to support video. And so, to ensure full and complete participation by all Workgroup members and the public, we want to mitigate the potential for technical difficulties that can sometimes arise when using video. Let me also remind folks of a few ground rules for participation today.

So first, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As members of this 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 perspective. So 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 from breaks so we can have everyone present for the discussion and voting on the measures that are being discussed today. And related to that, we want to make sure that all Workgroup members who wish to speak may do so. So, when you want to make a comment or ask a question, please use the Raise Hand feature in WebEx and we'll be 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 that public comment period. Next slide.

All right, now I would like to give our co-chairs Kim Elliott and Jeff Schiff an opportunity to offer their welcome remarks. Kim, would you like to go first?

Kim Elliott:

Are you able to hear me?

Patricia Rowan:

Yes, we can.

Kim Elliott:

Perfect. So, I am very happy to be here today with all of you and I am welcoming all of you to the Health Home Core Set Workgroup meeting. Like all of you, I'm very excited to be part of this important process. I really enjoy these meetings and I hope all of you do as well. Our Workgroup, of course, is charged with assessing the 1945 and 1945A Medicaid Health Home Core Set measures, identifying any gaps, and of course making recommendations that will really strengthen and improve the Health Home Core Set. You know, as we work over the next two days to review the measures, we consider a lot of different things, but we always keep the member at the focus of why we're doing this work, what is really going to improve care and outcomes for the individual served through the health home program. And then of course, the

other important thing that we really need to focus on is the state's ability to really have the data available and be able to calculate the measures to do the reporting that's required for the health home work.

I like to focus on the use of measures and how they will meaningfully drive improvement in healthcare delivery and outcomes for the member, again, keeping the member as the focus. And then there's the balancing of whether there are actions that can be implemented that are feasible and viable for the states to be able to report the measures or to improve the outcomes of those measures. So, with that, a lot of work ahead of us next days. I think we have an absolutely wonderful team on this Workgroup that has a lot -- brings a lot of expertise. So, I just want to say welcome to everyone and your participation and your focus throughout the meeting today and tomorrow is really going to make this an excellent meeting, so thank you.

Maria Dobinick:

Thanks so much, Kim. Jeff.

Jeff Schiff:

Can you hear me?

Maria Dobinick:

Yes, we can.

Jeff Schiff:

Great. Thank you. I'm going to just add a little bit to what Kim had to say. Kim, thanks very much. I think about these meetings, and I think about sort of the evolution of the set from 15 years, from -- of the Core Sets from 15 years ago till now. And the fact that 2024 the year we're in, although we're looking at measures going forward, is the first year where these measures will require mandatory reporting. And I think what Kim said about focusing on improving the lives and the wellbeing of our members, and I'll add the families of our members as a pediatrician and having accountability I think is really crucial.

I would say that health home and its underlying role to support care coordination for beneficiaries is everywhere, not just in the work in this in 1945 and 1945A, but also in CMMI models and then also in models that are being promoted on the HRSA side of the Health and Human Services world. So, I'm really very excited. I think we have a place, we have a, I guess I would say a milepost that we can set in the ground for what we think is important that can be done through the processes here. And it's a milepost that is paid attention to at other places in HHS federally and I think at other places and states. So important work and work that's all part of I would say hopefully a greater movement to support the folks who we all desire to serve. I'm going to turn it back over to you folks at Mathematica. Thank you everybody for being here.

Patricia Rowan:

Thank you, Jeff and Kim. Next slide. So now we'll take a moment to introduce our 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 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 new measures that will be reviewed by the Workgroup for potential addition to the Health Home Core Sets. During introductions, members are asked to disclose any interests related to the measures that will be reviewed by the Workgroup. Next slide.

So, as we go through the roll call, we ask that Workgroup members raise their hand in WebEx when your name is called, we will unmute you and you can say hello. Please share any disclosures you may have or indicate that you have nothing to disclose. We also have an icebreaker to start off the meeting, so please mention briefly one thing that you are looking forward to during this week's annual review meeting. And when you are done, please mute yourself in the platform, the WebEx platform, and lower your hand. This will allow you to mute and unmute yourself when you would like to speak during the measure discussions later on today. If you have to leave the meeting and reenter the meeting platform at any time or you find that we have muted you because of maybe background noise or something like that, just raise your hand and we will be sure to unmute you. Next slide.

So, on these next two slides, we have listed the Workgroup members in alphabetical order by their last names. When I call your name, please raise your hand so we can unmute you. And if you've also muted yourself locally on your headset or phone, please remember to unmute your own line so that you're not double muted. And if you have any technical issues, please use the Q&A function for assistance. So, Kim, starting with you, please indicate whether you have any disclosures and anything that you are looking forward to about this year's meeting.

Kim Elliott:

I have nothing to disclose and I'm looking forward to reviewing some of the measures that are really going to drive some of the more social areas and other aspects that really support the members in meeting their healthcare needs.

Patricia Rowan:

Great. Jeff?

Jeff Schiff:

I have, as it says here, I'm a senior scholar at AcademyHealth and I have nothing specific to disclosure around measures. I also do a bunch of work with the Maternal Child Health Bureau, kids with special healthcare needs, but nothing related financially or in any way to the measures. I am looking forward to the gap conversation in a big way because it's the -- we have the, I guess this gap conversation is a prequel to an open call for measures. And I think that I'm looking at gaps that we have the potential to fill in reality and gaps that we may be more aspirationally will fill in the future. Thanks.

Patricia Rowan:

Thank you, Jeff. David.

David Basel:

Morning, I have nothing to disclose and kind of similar to Dr. Schiff, I'm looking forward to more of the discussion on gaps and prioritization of measures. I feel that that's part of this committee's

responsibility, not just to propose and approve new measures, but to help set the priorities because there's limited resources for improvement across all of our organizations. And having a discussion about where to start and where to prioritize is an important part of these discussions in my opinion.

Patricia Rowan:

Great. Thank you so much for being here. Macy.

Macy Daly:

Hello. My name is Macy Daly. I just changed my name recently from Mackenzie. I don't have any disclosures. And I am really looking forward just to hearing other perspectives and, you know, sort of the reasoning behind some of the measures and what we can gain from them and how other organizations, you know, see that they'll be beneficial and how they're going to be collected. So, I just, you know, the group knowledge is what I'm looking forward to. Thanks.

Patricia Rowan:

That's great. Thank you. And just to confirm you do not have any disclosures, is that right?

Macy Daly:

Correct. No disclosures.

Patricia Rowan:

Great. Thank you. Ari. Do we have Ari Houser? Ari, we might have lost audio. Do we have Ari Houser? Hi Ari, go ahead.

Ari Houser:

Hi, this is Ari Houser. I think my turn is up, but my audio just went out for about 20 seconds, so--

Patricia Rowan:

Just one time. Go ahead.

Ari Houser:

I so my name is Ari Houser. I am a statistician and policy analyst with the AARP Public Policy Institute. I have no interests to disclose, and I'm really looking forward to the discussion about the third measure on Social Needs Screening and Intervention. I'm not a medical doctor, and really the social need is something that I find very important and very interesting and really in my interest area as a policy researcher.

Patricia Rowan:

Great. Thanks so much for being here. Amy.

Amy Houtrow:

Hi everyone. My name is Amy Houtrow, how now brown cow, ciao for now. And I am without any disclosures and really looking forward to what I believe is my last meeting to learn and gather all the wisdom from the group. Thank you very much.

Patricia Rowan:

Thank you, Amy. Pamela Lester.

Pamela Lester:

Okay. I am the quality person and I have no disclosures and I am interested in discussing the proposed measures as we focus on comprehensive care for those that are potentially high risk. And then I'm also interested in reviewing gaps and comparing them to some of our previously identified gaps to see if those have changed or those gaps have decreased.

Patricia Rowan:

That's great. Thank you, Pamela. Your audio got progressively better as you were talking, so thanks so much for staying near your microphone. Let's go to the next slide, please. All right, so Elizabeth, Libby, let's continue with you.

Elizabeth Nichols:

Hi, I'm Libby Nichols. I have nothing to disclose. I'm from New York State Department of Health, and I'm looking forward to hearing other states' perspectives on the measures and the gaps. I always find it really interesting to hear what other states are doing and how they look at these measures, these problems. So yeah, happy to be here.

Patricia Rowan:

Thank you so much for being here. Kayla, do we have Kayla Romero?

Kayla Romero:

Kayla Romero. I have no disclosures. This is my first meeting, so I am excited to participate. I am looking forward to hearing other perspectives when reviewing the measures and ensuring that they are prioritized. Thank you.

Patricia Rowan:

Thank you, Kayla. We're happy to have you. Pamela Tew.

Pamela Tew:

I work for Healthy Steps. I have no disclosures to report, and I am -- this is also my first time participating, so I'm excited to learn more about the process and give the early childhood perspective.

Patricia Rowan:

Thank you for being here. Sara Toomey.

Sara Toomey:

Hi, I'm just Sara Toomey. I have nothing to disclose, and I think I'm most excited for tomorrow's conversation regards to gaps. I think it's always great to hear from everybody and really challenge us to think about what we should be measuring moving forward. Thank you.

Patricia Rowan:

Great. Laura Vegas.

Laura Vegas:

I work with the National Association of State Directors of Developmental Disability Services. Really happy to be here with this group today. I have nothing to disclose and I'm looking forward to the gaps conversation as well, especially around the area of the coordination component of the health homes. Thanks.

Patricia Rowan:

Thank you for being here. And last, we have Jeannie Wigglesworth.

Jeannie Wigglesworth:

I'm Jeannie Wigglesworth, and I work in Connecticut for Carelon Behavioral Health, representing the Department of Social Services. I have no disclosures and I am very interested to go into the conversation around the social needs screening and intervention. I think the last conversation we had is we knew it would be sort of a difficult conversation on how we would be collecting this. So, I'm interested to open up that conversation again. We've been thinking about this a lot in Connecticut, so --

Patricia Rowan:

That's great to hear. We're looking forward to your perspective on that. And my apologies for the typo on the slide. We will be sure to get that corrected for tomorrow. All right, next slide.

So, we are also joined today by federal liaisons who are non-voting members of the Workgroup. I will read the names of the agencies, but we won't do an individual roll call. So, we have 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 Health Promotion, the Office of Minority Health, and the Substance Abuse and Mental Health Services Administration. Federal liaisons, if you have any questions or comments during the Workgroup discussion, please raise your hand and we will unmute you. And I would also like to take the opportunity today to thank our colleagues in the Medicaid Benefits and Health Programs Group at the Center for Medicaid and CHIP Services, and also all of the measure stewards who are attending today and available to answer questions about their measures. Next slide.

Now, I would like to introduce Sara Rhoades, the Technical Director of Health Homes in the Medicaid Benefits and Health Programs Group at the Center for Medicaid and CHIP Services to make some welcome remarks on behalf of CMCS. Sara, the floor is yours.

Sara Rhoades:

Hello. Can everyone hear me?

Patricia Rowan:

Yes, we can hear you.

Sara Rhoades:

Okay, thanks. So, welcome everyone. I just want to take the time on behalf of CMS as well as health homes group to thank everyone for attending and just for -- not only for your time, but for all your thoughtful consideration and being part of this group and bringing all of your expertise and knowledge to this Workgroup and helping us ultimately better serve the beneficiaries that are part of these programs. And so as we -- moving forward with both 1945 and 1945A some of, again, top priorities that continue for CMS is looking at obviously gaps, disparities in health and we are also looking towards the stratification.

So, as we've mentioned, so 2024, this year's reporting is mandatory, but moving beyond 2024 we will be starting to stratify some of the measures. And so when you're considering measures and when you're thinking about as you vote on these upcoming measures, you know, the ability to not only capture things at a program level, to actually be able to have data that we can see how effective health homes is being or not being for the beneficiaries that are being served. But also, how well some of that data can be filtered in order to really capture who's being served and who's not being served in these programs to make sure that we are meeting the needs of all beneficiaries. So just a couple key thoughts from where CMS's priorities are as well. And again, welcome and thank you all so much for being part of this. I'll turn it back over. Thank you.

Patricia Rowan:

That's great. Thanks so much, Sara, for being here and for your remarks. And at this point I'm going hand the microphone back to Maria to kick off our discussion for today.

Maria Dobinick:

Thanks so much, Tricia. All next slide, everyone. So, before we review the measures today, we would like to provide some background information on the 1945 and 1945A Health Home programs to help inform the measure discussion and orient the perspectives as the Workgroup considers these measures for addition to the Health Home Core Sets. Next slide.

Let's begin with the 1945 Health Home Programs. The Affordable Care Act authorized the Medicaid Health Home state plan option 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 are able to 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'll notice that we refer to program level performance. 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, or those with a serious mental illness. Chronic conditions include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions such as HIV and AIDS may be considered by CMS for approval. Next slide.

Now, let's turn to the 1945A Health Home Programs. 1945A is the second type of Health Home program and it is the newest, a new state plan option that went into effect October 1, 2022. It does not replace 1945 Health Home Programs. Rather, it offers a similar benefit to cover health home services for Medicaid eligible children with medically complex conditions as defined in section 1945A of the act. A state Medicaid director letter dated August 1, 2022, is linked in this slide and provides the full details about this benefit. Next slide.

So, let's review the goals of the 1945A Health Home program. The first goal is to coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times. Next, to develop an individualized, comprehensive pediatric family-centered plan for children with medically complex conditions that accommodates patient's preference. The next goal of the 1945A Health Home program is to work in a culturally and linguistically appropriate manner with the child, the family of the child with medically complex conditions to develop and incorporate into such child's care plan in a manner consistent with the needs of the child and the choices of the child's family.

Another goal of the program is 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. This also includes palliative services if state provides Medicaid coverage for such services. And the last goal is to coordinate care for children with medically complex conditions to out-of-state providers, furnishing care to the maximum extent practical for families of such children and where medically necessary in accordance with the guidance issued under a subsection E1 under Section 431.52 of Title 42 of the Code of Federal Regulations. Next slide.

Another way in which 1945 and 1945A Health Home programs differ is by the eligibility criteria. This is a shift from the 1945 Health Home Programs where it is chronic condition focused. 1945A programs are specifically targeted at age in the pediatric population. CMS defines the pediatric population for this option as those under the age of 21. The child must also be eligible for medical assistance under the state plan or waiver of such plan, which CMS interprets to include eligibility under an 1115 demonstration. A child with medically complex conditions must have at least one or more chronic conditions that affect three or more organ systems and severely reduces cognitive or physical functioning such as the ability to eat, drink, or breathe independently and also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments. Or a child is eligible for this program if they have one life limiting illness or rare pediatric disease as defined by the Food and Drug Cosmetic Act. Next slide.

This slide is a comparison of the core services provided by 1945 Health Home Programs and 1945A Health Home Programs. As you can see, most of the core services are the same. Although the 1945A Health Home programs include some additional services such as the care coordination, health promotion, provision of access to a full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers as medically necessary. It has comprehensive transitional care, including appropriate follow-up from in-patient to other settings, and patient and family support, including authorized representatives.

And finally, the use of health information technology to link services as feasible and appropriate. Next slide.

So, the last bit of information for this section that we'd like to discuss for Workgroup consideration is preparing for mandatory reporting and measure stratification. As you may know, beginning later this year, reporting of all Health Home Core Set measures will be required for all states with approved health home programs in operation by June 30th of 2023. States must also adhere to Core Set reporting guidance issued by CMS. For more information on mandatory reporting requirements, you can visit the link provided on this slide. So, we ask that the Workgroup considers the feasibility and the viability of program level reporting of the current and future Health Home Core Set measures as they are key considerations as mandatory reporting begins. We also ask the Workgroup to consider whether a measure could be stratified by factors such as race, ethnicity, sex, geography, age, disability, and language. The stratification of Health Home Core Set measures will be required beginning with 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. Guidance on stratification for the Health Home Core Sets is available at the link included on this slide.

Workgroup recommendations for the 2026 Health Home Core Sets should consider the feasibility for all states with approved health home programs to report the measure for all beneficiaries enrolled in their program within two years of the measure being added to the Core Sets. Next slide.

So that was a lot of information and I'm going to pause here so we can take questions from the Workgroup members before we transition to talking about the voting approach. I am not seeing any questions. Okay. If you have a question, please remember to raise your hand using that Raise Hand option and we will be able to unmute you so you can ask your question. All right, I'm going to move on. We will have plenty of space for additional questions. Okay, next slide.

So, we're going to start the measure discussion shortly, but first we want to really talk about the approach to the measure review and do some practice voting. Next slide. I'm going to provide a quick recap because most of us were just together two weeks ago during the Workgroup meeting to prepare for voting, but for folks who might be seeing this for the first time, these slides and background materials from that prep meeting are available on our website. The Medicaid Health Home Core Sets Workgroup for the 2026 Annual Review is charged with assessing the 2025 Medicaid Health Home Core Sets and recommending measures for addition or removal in order 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.

So, as we've done in the past, we wanted to share this slide which really highlights the balance that the Workgroup faces in assessing measures in terms of their feasibility, desirability, and viability. And our goal in this year's review is to optimize the overlap of these three elements. The technical feasibility of collecting and reporting measures, the desirability of measures which relates to their actionability and strategic priority, and the financial and operational viability such as alignment across programs and state capacity for reporting, particularly at the program level.

There are many, many good quality measures, but we need to keep in mind that the measures must be good for use in program level quality measurement and improvement for Medicaid

Health Home Programs. We also give you here an example of the types of trade-offs that Workgroup members should consider. While outcome measures might be more desirable than process measures, the Workgroup also needs to consider the feasibility and viability for program level reporting. For example, quality measures that reflect health outcomes might be more desirable than process measures, but they may be more challenging for states to report based on data availability and resource intensity. Next slide.

And so, for many of you, this graphic is also familiar. This 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. 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 program as a whole. CMS values alignment of quality measures across programs and levels because it can really help drive quality improvement by addressing each level of care so that improvement at one level may lead to improvement at other levels. Moreover, alignment is intended to streamline data collection and reduce reporting burden. Next slide.

Now, let's share a little bit of information about the Health Home Core Sets overall to provide some high-level context for our measure discussions. The 2025 1945 Health Home Core Set includes 11 measures and there is no target number of measures, either maximum or minimum expected for this Core Set. We encourage Workgroup members to consider each measure on its own merits according to the criteria that we're going to discuss. In terms of reporting on the 1945 Health Home Core Set, federal fiscal year 2022 is the most recent cycle for which data are available. Of the 38 approved health home programs expected to report in FFY 2022, 34 reported at least one measure. States reported a median of 10.5 measures, and reporting remained consistent or increased for 23 of the 30 health home programs that reported for all three years from FFY 2020 to FFY 2022. Eleven of the 13 FFY 2022 Health Home Core Set measures were reported for at least 20 of the approved health home programs. Next slide.

The 2025 1945A Health Home Core Set includes six measures and just like the other Core Set areas, no target number of measures, either maximum or minimum. And we still encourage you to consider all of the measures on our own merit and according to the criteria. To date, there are no approved state plan amendments for the 1945A Health Home State Plan option. However, we do know that one state is currently utilizing a planning grant and there is another state with a legislative mandate to submit a state plan amendment by January 1 of 2025. And so this means that there are states on track to report on the FFY 2026 1945A Health Home Core Set that the Workgroup will be considering measures today and tomorrow. Next slide.

It is important to note that measure stewards typically update various aspects of quality measures technical specifications each year and changes 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 each measure. They also reflect public information and information from the measure stewards as current as May 2024. Though it is important to note that measures may continue to undergo additional updates between now and when a measure specification for FFY 2026 reporting is finalized. Next slide.

So now we're going to shift gears a little bit and talk about the criteria for reviewing measures and share some voting logistics. Next slide, please. In each meeting we always come back to our established criteria in three ways for assessing measures. First, minimum technical feasibility, actionability and strategic priority, and other considerations. We know many of you have seen these slides several times before. However, as some folks noted during the Workgroup roll call, we do have some new members this year. There are also public attendees in the audience, and we really want folks to understand this because these criteria are foundational to the discussions over the next two days. So, we want to remind folks that to be considered for FFY 2026 Medicaid Health Home Core Sets, all measures must meet minimum technical feasibility requirements. Next slide.

So, as I just mentioned, our 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 program level. They've been tested in or are in use by at least one Medicaid or CHIP program. They have an available data source or validated survey that includes an identifier for Medicaid beneficiaries and their specifications and data source allow for consistent calculations across states and programs. 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 criteria as you are going into your voting and discussions. Next slide.

The second category is actionability and strategic priority. 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 of disparities. They should address a strategic priority in improving healthcare delivery and outcomes and we want them to be able to assess program level progress in improving healthcare delivery and outcomes. Next slide.

Finally, there's a few other criteria to consider. Is the prevalence of the condition or outcomes sufficient to produce reliable and meaningful results across health home programs? Is the measure aligned with those used in other CMS programs? Will all health home programs be able to reproduce the measure within two years of the measure being added to the Health Home Core Sets? Next slide.

So, this year no measures were suggested for removal from the 2026 1945 or 1945A Health Home Core Sets. However, this slide is a good reference point for Workgroup members, particularly as you prepare for tomorrow's discussion around gaps and future considerations for the Health Home Core Sets. Next slide.

Okay, so again, that was a lot of information, so I'm going to take another pause to answer any questions before we transition into voting logistics and practice voting. So, if you have any questions at this time, please remember to raise your hand using that little hand option down in the lower left-hand corner and we will call on you. All right, I do not see any questions at this time, so next slide. All right, with all of the criteria in mind and all that background about the health home programs, I'm going to now hand it over to Emily who is going to provide an overview of the voting process and walk everyone through some practice votes.

Emily Costello:

Thanks, Maria. Next slide. Next slide, please. Not sure if you can hear me.

Maria Dobinick:

There we go.

Emily Costello:

Thank you. All right, voting will take place after Workgroup discussion and public comment on the measure or group of measures that is being reviewed. Voting is open to 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 Q&A function and WebEx if they will be absent for a portion of the meeting. Each measure will be voted on as it is currently specified. For those measures being considered for addition, a yes vote means, "I recommend adding this measure to the Core Set." Measures will be recommended for addition if 2/3 of eligible Workgroup members vote yes. Now, we're going to move into a couple of practice votes. As a reminder for all attendees, voting will be for Workgroup members only. Workgroup members, make sure 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, you may use your cell phone and scan the QR code shown on 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 address where you receive correspondence from our team as you will receive a code from Slido to access the section where to cast your vote. It is suggested that you keep the voting page open 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 Section 1 of the voting guide, which we emailed you, or send us a chat through the Q&A feature on the WebEx platform. During voting on measures if for any reason you are unable to submit your vote, please send us your vote through Q&A or to our email address if you are not able to access WebEx. Your votes will be visible only to the Mathematica team. Next slide.

Although -- oh, I'm sharing my screen so there's not a next slide. Now, I will open up our first practice vote. So, the question here is do you prefer dogs over cats? The options that should appear on your voting page are, "Yes, I prefer dogs," or "No, I prefer cats." And if you aren't seeing the question, try refreshing your browser. So go ahead and submit your votes.

Maria Dobinick:

Thanks, everybody, for hanging with us. The first practice vote is always the one that takes the longest as our Workgroup members log in and do their first vote. We are just about there. I think we are waiting for one Workgroup member. I am going to ask Talia; do you have a quick update for us? All right, it looks like we might be at 13, is that right? Are we at our magic number, Emily?

Emily Costello:

Yes.

Maria Dobinick:

Perfect. Thanks, everyone, for your patience as we got through that.

Emily Costello:

All right, and I'll -- okay, so it looks like we're majority dog lovers here. Now, we will do one more practice vote. All right, so the next practice vote is, "Are you right-handed?" The options that should appear on your voting page are, "Yes, I am right-handed," or "No, I am left-handed." And again, if you aren't seeing the question, the answers, try refreshing your browser.

Maria Dobinick:

If you've been with us before, we know that each time we get a little bit quicker at this, but we are still doing our practice votes. So, thank you to everyone for hanging in with us while we wait for everyone to get these votes submitted. Looks like we are still waiting for two Workgroup members to cast their votes. We are waiting to know if the last person is a lefty or a righty. Looks like we have it.

Emily Costello:

Okay, awesome. All right, end voting and -- oh wow, there's a lot of lefties here. So, thank you everyone for participating in our practice votes. With that, we will now take a break. If there are any Workgroup members that have additional questions about the voting platform, please feel free to message us and we can work to answer your questions over the break. And let me -- Maria, what time should we have everyone return from break?

Maria Dobinick:

Hey, thanks. We are going to have everybody come back at 12:45, and when we hop back at 12:45, we will begin right off with our measure discussion and voting. So please come back as quickly as you can. And again, if any Workgroup members are having any problems, technical difficulties over the break, please do feel free to message us through the Q&A or send us an email, and we will see you all shortly for our measure discussion.

Kalidas Shanti:

Hi everyone. Welcome back from the break. My name is Kalidas Shanti and I'll walk through the first two measures suggested for addition. Next slide. Thank you. The first measure suggested for addition of the Workgroup we'll discuss this year is Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications or SSD. This measure is defined as the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder were dispensed in antipsychotic medication and had a diabetes screening test during the measurement year. The National Committee for Quality Assurance is the measured steward and SSD is a process type measure. This measure is being considered the 1945 Health Home Core Set and is an existing measure in the Adult Core Set. This measure is not being recommended to replace the current measure, and the data collection method is administrative. Next slide.

The denominator for this measure includes beneficiaries with schizophrenia or bipolar disorder who meet at least one of the two following criteria during the measurement year. First, at least one in-patient encounter with any diagnosis of schizophrenia, psychoaffective disorder, or bipolar disorder. These encounters are identified by code combinations for either a behavioral

health standalone acute in-patient value set with the schizophrenia value set, bipolar disorder value set or other bipolar disorder value set. Or with a visit setting unspecified value set with an acute in-patient point of service value set, the schizophrenia value set, bipolar disorder value set, or other bipolar disorder value set.

Our second, at least two of the following encounters -- on different service dates where both encounters have any diagnosis of schizophrenia or psychoaffective disorder or both encounters have any diagnosis of bipolar disorder as indicated by the utilization of respective value sets. These encounters can occur in the settings listed below when indicated via use of the value sets detailed and the measure specifications for outpatient, intensive outpatient or partial hospitalization, community mental health center visits, electroconvulsive therapy, emergency department visits, a non-acute in-patient encounter, telehealth and other e-visit or check-ins. Next slide.

The numerator for this measure is a glucose test or HbA1c test performed during the measurement year. The current technical specifications for this measure do not include guidelines for stratification and the measure steward notes. There are no planned or proposed changes pending for stratification of this measure. This measure has not been identified by CMS for mandatory stratification for the federal fiscal year 2025 Adult Core Set Reporting. A Workgroup member who suggested the measure for addition indicated that there is a gap in measures that focus on integrated primary care and behavioral health on the 1945 Health Home Core Set.

A Workgroup member also stated that the measure prioritizes chronic conditions and evidence-based healthcare, and then added that those with chronic conditions such as diabetes and mental health conditions are priority populations for 1945 Health Home Programs. A Workgroup member also noted that the cost of care for enrollees with diabetes is high. Additionally, individuals with uncontrolled diabetes who also have schizophrenia and bipolar diagnoses prone to poor outcomes. So, there is an urgency for direct focus to this population. During the federal fiscal year 2025 Health Home Core Sets Annual Review, the Workgroup discussed diabetes management as a gap area and identified an opportunity to align with the Adult Core Set by considering measures of diabetes management for enrollees with chronic conditions in future Workgroups. Next slide.

I'd now like to hand it back to Tricia to facilitate a Workgroup member discussion of the Diabetes Screening for People With Schizophrenia Or Bipolar Disorder Who Are Using Antipsychotic Medications or SSD measure.

Patricia Rowan:

Great. Thanks, Kalidas. So, this brings us to our first discussion of a measure of today's meeting. So as a reminder, this opportunity for discussion is for Workgroup members and federal liaisons. So, if you have a comment or a question about this measure, please use the Raise Hand feature and we will unmute you if you wish to speak, and please remember to just say your name before making your comment. I see Jeff has his hand raised. Derek, can we unmute Jeff? Go ahead.

Jeff Schiff:

I have actually two questions that may be more appropriate for the measure developer, but I want to know two things. One is, has this measure been split? Because it's a schizophrenia or

bipolar disorder. So, has the denominator ever been split to see the prevalence of both of these conditions and then also the results by condition? And then my second question is a numerator question, which is that the numerator allows for glucose testing or hemoglobin A1C. And it seems like there's also a significant difference in accuracy, I suppose, of whether somebody has pre-diabetes or is at risk and needs some more careful management depending on whether we look at that. So, I'm also curious about how frequently the numerator is a glucose test versus a hemoglobin A1C.

Patricia Rowan:

So, Jeff, thanks so much for those questions. We do have Tom Valentine from NCQA on the line. Tom, are you able to respond to any of Jeff's questions? We may need you to raise your hand. Yes, we can hear you.

Tom Valentine:

Great. So, I would definitely have to do some digging into the initial development of the measure to see if we have any data regarding prevalence of bipolar versus schizophrenia with regard to this measure. I know that we don't routinely stratify in that way. We don't break down the measure in that way, but that might have been part of the initial measure development. Similarly, with the HbA1c versus glucose testing, that's something that we might have some data on from initial measure development. And it might be information that we can obtain ongoing, but it's not something that we stratify by automatically. So those are things that I could get back to the group about.

Patricia Rowan:

Thanks, Tom. Other comments or questions from Workgroup members? I see Jeannie has her hand up.

Jeannie Wigglesworth:

Hi. I just wanted to say that in Connecticut we are doing this measure just as a Connecticut specific measure. We were using part of the CDC measure until that was retired. So, we switched over to this because it is part of our HEDIS group set. And just to talk a little bit -- those two diagnoses are just -- they fall under the SMI kind of grouping of diagnoses. So, when we first did this measure, you know, we were a little concerned that we would lose a lot of people in our population because we target the SMI population. But in actuality, we really didn't lose too, too many. So that's probably why they are grouped that way. So, I just wanted to comment on that. I mean, we have not separated out diagnoses, but that is -- you know, my guess is why those certain diagnoses are included or incredibly similar to our eligibility for SMI. So --

Patricia Rowan:

Thanks, Jeannie. That's really helpful. Other comments or questions from the Workgroup? Kim, go ahead.

Kim Elliot:

Yeah. One of the things I like about this measure is because of the types of medications that are prescribed for those diagnoses and the increased risk of diabetes for the individuals that are

prescribed those types of medications. So the better job we do at testing for diabetes or pre-diabetes for individuals that are taking those medications, the better chance we have at -- particularly in a health home situation where we're able to put some resources around it and make sure that the condition doesn't -- that it's more controlled, I guess is what I'm trying to say. So, I think it's a really valuable measure. I don't know that it's a significant amount of members in the population. I haven't looked at the actual penetration rates or anything like that, but just the thought of keeping the people at their healthiest and having a better quality of life with all of the other situations occurring that I think it's a valuable measure.

Patricia Rowan:

Thanks, Kim. Ari?

Ari Houser:

Hi. This comment goes both for this measure and for the next measure, which seemed to be a set, one for adults, one for children. And I am fully sold on the need, the importance of screening for diabetes. The evidence that this specific subpopulation is at higher risk and there's reason to specifically look at the subpopulation, as well as the alignment with the Adult and Child Core Sets. My question is that out of all of the diabetes screening measures, is this one or are these two the best measures to include? And I know that's not our vote. Our vote is either we recommend this measure, or we don't. But I guess I would be interested in hearing, you know, are these the right diabetes screening measures? Or are there others that perhaps we should consider to be superior that maybe we want to wait and use one of those?

Patricia Rowan:

Thanks for that comment, Ari. Kim.

Kim Elliot:

Sorry, I just forgot to take my hand down.

Patricia Rowan:

Oh, okay. No problem. And Jeannie, did you have something else to add, or is your hand still up from earlier?

Jeannie Wigglesworth:

No. I did want to say something else. Only -- and I'm trying not to talk from just our Connecticut perspective, but this is a great measure for preventative reasons. I just want to piggyback on the previous comment of trying to catch people before they get diabetic. Again, I kind of respect the last comment as whether this is the best measure for the total national population. I don't know the ratio of health homes and who focuses on what. We focus on the SMI, so this is very important, right? Most of our population is older and already are suffering from diabetes. So, to be able to connect, especially with the younger population, and to get these screenings, it is vital. But I think the last question does bring a good point is how do we determine these measures, you know, depending on the variety of different populations that are included in these health homes, you know? Because one measure may be perfect for Connecticut, but not for

another state, you know? Sometimes it's hard to vote on that, you know, -- on a national level, I guess.

Patricia Rowan:

Yeah. Absolutely. Libby.

Elizabeth Nichols:

Hi. I'm Libby. I really liked that comment about just the notion that it's hard to -- the more specific measures get, the more difficult it is to really think about what that means for a national -- -- a program where each state really has some variation compared to the next state. And I think that's like particularly relevant as these become mandatory that -- you know, just the more specific the measure, the harder it is to understand whether it's a -- you know, whether it's going to work for every health home population. This is like my other thought -- and I'm not like putting my thumb on the scale. I'm really kind of interested in hearing what others think about this is that, you know, one of the things that really struck me in the introductions was, I think it was maybe Kim that had some said something to the notion of like, it's helpful to think about what are the actions that a health home could do to impact this measure. And I think my -- what I'm trying to like, think about in my mind is, you know, health homes are primarily care coordination entities, right? Like that's really their goal.

So, they're not necessarily, per se or might not be necessarily, doing the glucose test, but they could encourage primary care visits or, you know, connections to other follow-up. And certainly there's, I think, a really good argument to be made of if that screening is positive, they have a role in making sure someone is connected to further services and follow ups. I'm interested in hearing what other folks think in terms of like the health home's role impacting this specific measure and how they see those two things tying together.

Patricia Rowan:

Jeannie, go ahead.

Jeannie Wigglesworth:

It's one of my favorite measures. So, for the health homes, one of the interventions would be for our providers to be connected with the psychiatrist or the person who's prescribing the antipsychotic medication. And if this is a case where this individual -- so we collect a lot of different data points, some of them that the health homes collect some of them; it's collateral from the medical providers. But if they have -- and then I provide them dashboards that kind of combine a bunch of this information. If they have an individual that has some of these key components that put them on that metabolic syndrome train, and then they're also on a medication that may raise their A1C and now they got a test back that they're close, their next step would to be, you know, to inform the psychiatrist is there another medication this person could take? Also, it bumps them into like health promotion groups and other things that can help them you know, sidetrack that track to diabetes, I guess.

Patricia Rowan:

Thanks for that, Jeannie. Other thoughts or questions or comments on this measure? David.

David Basel:

Thank you. David Basel -- Avera. My comment is probably a similar one I'm going to make on all of these metrics as I think about kind of this Workgroup's role. I think a little bit more broadly about measurement and prioritization. And so, is this a good measure or all the other measures we're talking about today, reasonable measures? Absolutely. Are the important measures? Absolutely. But how do we fit them in the greater priorities? And in general, I think most of our programs have a finite level of resources to put towards measurement and improvement. And a vote towards adding any given measure is really a matter of prioritization. And if everything is a priority, then nothing is a priority. And adding in a new measure means you're going to be spending less time measuring other things, and it's generally the same resources you use for an improvement.

And so, it means you're going to be spending less time on improvement. And so, my general preference is that we're taking away a measure for adding a measure, and that's part of our responsibility to say we feel this is more important than the existing measures. And that's why we want to add it and be very intentional about removing something else to -- as we shift our priorities in the program. And so, I'm kind of concerned that we're not proposing to remove any metrics if we're going to replace one of them. And a vote to add one is just by default, you're going to spend less time, finite resources, on that. And so that concerns me in general because there's probably 100 great measures that are just like this one that are, you know, evidence-based.

It's part of our important, we should always be screening patients with antipsychotics for metabolic disorders and following that. But it's a matter of prioritization for me that I struggle with this and all the other measures we're talking about today. Since we aren't removing any, it's just so easy for us to get caught in that trap with just adding more measures and more measures, especially as we're going to mandatory reporting. And that's without us really thinking deeply about that's really diluting the efforts that we can put towards other metrics that we've already said are a priority. And it's just a greater priority than those, because a new measure being added will automatically make it a resource intensive and takeaway resources from everything else that we're doing.

Patricia Rowan:

Thank you for that comment. Amy?

Amy Houtrow:

Hi everyone, this is Amy Houtrow. And my comment is about how we would then approach the work of this committee if we were to take that kind of more global frame, which I think is really an important frame to be thinking about. Like this is about prioritization and limited time and labor and technology capabilities because I don't feel like we're particularly well set up to do that in this process. And while I really appreciate it, I just am wondering how we would go about operationalizing it.

Patricia Rowan:

It's a good question. And I think it will be one that comes up a lot during tomorrow's discussion about a transition to a Public Call for Measures where there will be, you know, more opportunity to bring measures to the forefront, both for addition and removal. But it's a really good point.

The Workgroup charge right now is really just to review and suggest recommendations for the measure set, you know, as measures are suggested, but we appreciate the comment for sure. Other questions or comments on this measure? Kim.

Kim Elliot:

I'm thinking about some of the most recent comments and discussion. I don't view this as much of an administrative burden to people that are working on or involved in the health home. Particularly from the measurement perspective since it's administrative data that's rather easy to collect, it doesn't involve as many resources. But really it does involve additional time, effort in the care coordination department. And that's where I think the focus really is for this measure is making sure that we are including things that will have a significant health or other impact, the health, wellbeing, quality of life of individuals served in a health home. So really understanding the risk of diabetes or pre-diabetes and doing the testing so that we can ensure that that care is coordinated if there is a result or outcome that could have an impact on that person's life or health. I think that's something that is worthy or worthwhile from a measurement perspective.

Patricia Rowan:

Thanks for that perspective, Kim. Libby.

Elizabeth Nichols:

I just want to like clarify my -- and maybe I'm being stuck in details a little bit, but I kind of have a little bit of a similar thought to, I think it was David who had said, you know, if we're going to add something, I think we should really be thoughtful about it because even if something is administrative and easy, if you're adding a measure, there's attention to kind of like how that measure is performing and it divides resources, you know, and kind of the attention sphere.

So, I think while it's -- I think it's really totally on point that care coordination would be required for someone who has results from a screening that indicate more care is needed. I don't think you could argue against that. But my question is sort of to the point of -- the measure really is did someone get a screen or not? In this population, did someone get a screen? And whether it's the responsibility of the health home to -- certainly they can do things to help that screening happen necessarily, but whether it's fair to be measuring them on whether someone got a screen or not. Not necessarily whether they got coordination after that screen because we'd obviously want that to happen, but are the health homes influential in whether or not someone gets a screening, since that's really what the measure is targeting, and do we want that to be the priority, I guess?

Patricia Rowan:

Thanks, Libby. Jeannie.

Jeannie Wigglesworth:

I'm sorry, this, Libby, I must comment. So, we do have reports that are kind of pre-reports to this that are -- In Connecticut, we have two ASOs, one for behavioral health Medicaid, and one for medical. And so, the medical gives us reports kind of ahead of time on anyone. They were kind of going through the denominator of CDC, and so they'd let us know if someone, you know, met that criteria to be in the denominator and if they required a screening or not. So, then the

behavioral health providers, because technically, you know, they tend to have a better rapport with the behavioral health providers, the SMI population, and the medical, they would be the ones trying to encourage them to, you know, go to their medical appointment. So that's how that piece would be the intervention to getting a screening.

Patricia Rowan:

Thanks, Jeannie. Other questions or comments on this measure? All right. Well, why don't we go to the next slide. We would like to offer an opportunity for public comment on the Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. So, if you are a member of the public and you have a comment, please use the Raise Hand feature in the bottom right of the participant panel to join the queue and lower your hand when you are done. We will let you know when you've been unmuted and ask that you introduce yourself and your affiliation before making your comment. I am not seeing any hands raised for public comment. So, before we move on to voting, let me provide one final opportunity for comments or questions on this measure from either members of the public, the Workgroup, federal liaisons or other attendees. Sara.

Sara Toomey:

Reflecting on where this fits into the set as a whole. And I think I'm, you know, I'm more pediatric focused admittedly. But as I look across the adult set, you know, I don't know -- while this is obviously a measure that's involving diabetic screening, the flip side, in terms of the patient population that it's addressing, there seems to be a number of -- and admittedly this would be a potentially -- a different patient population in regards to mental illness, but there are quite a number of measures around mental illness.

I guess one question I've not asked and apologize for not knowing, as you look at who's using these -- which patients are qualifying in states, is this an adequate representation of sort of the -- as we think, once again about trying to be parsimonious and adding measures when, you know, judiciously, is this a patient population that would be large enough in most states that this would benefit? I'm not sure if my question is making sense and I'm not 100 percent sure if you know the answer.

Patricia Rowan:

Yeah. It's a good question, Sara, particularly because we do have a criteria around the prevalence of the thing that's being measured. I wonder, Tom, from NCQA, if you're still on the line, if you all have any feedback on prevalence in Medicaid or CHIP?

Tom Valentine:

I can speak more broadly to prevalence rates in the general population. For bipolar disorder, generally between 2 and 1/2 and 3 percent and schizophrenia would be around 1/2 percent for prevalence, again, general population.

Patricia Rowan:

Thanks, Tom. Any other comments or questions on this measure from the Workgroup or members of the public before we move on to vote? All right. I am not seeing any more hands raised. So, thanks everyone for your comments. We really appreciate the engaged discussion.

And so, at this point, let's move on to our first vote. I believe we can either go to the next slide or -- yep, there we go.

Emily, are you bringing up the Slido? All right. So, the question is, "Should the Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure be added to the 1945 Health Home Core Set?" The options are, "Yes, I recommend adding this measure to the 2026 1945 Health Home Core Set," or "No, I do not recommend adding this measure to the 2026 1945 Health Home Core Set." Voting is open. I see the vote numbers are ticking up. We are expecting 13 votes. We have 12. If you are having any challenges with voting, please let us know in the Q&A. Oh, I see 13. Let us just confirm that we have all of the votes we are expecting. We do appreciate you all sticking with us. This is a new voting platform this year, and so we are all learning. Just give the team one minute before we share the results. All right. We have confirmed we have all the votes we have expected. So, let's close the vote and show the results. All right. So, 54 percent of Workgroup members voted yes. That does not meet the threshold for recommendation.

So, the diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications is not recommended by the Workgroup for addition to the 2026 1945 Health Home Core Set. Just as a reminder we use a 2/3 threshold. So that's the percentage threshold that we're looking for here. I do want to create a space very briefly that since the measure was not recommended for addition, for any Workgroup members who did not recommend the measure to make any comments before we move on. Okay. I am not seeing any hands raised to make final comments on that measure. So, at this point, I am going to hand it back to Kalidas to discuss the next measure that has been suggested for addition.

Kalidas Shanti:

Thank you, Tricia. Okay. So, we will now be reviewing Metabolic Monitoring for Children and Adolescents on Antipsychotics or APM. This measure assesses the percentage of children and adolescents age one to 17 with two or more antipsychotic prescriptions who had metabolic testing. Three performance rates are reported for this measure. The percentage of children and adolescents on antipsychotics who received blood glucose testing, the percentage of children and adolescents on antipsychotics who received cholesterol testing, and the percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing. Measured steward is the National Committee for Quality Assurance, and the measure type is process. Measure is not recommended to replace any current Health Home Core Set measures. This measure is included on the Child Core Set. The data collection method as HEDIS Electronic Clinical Data Systems. And the Electronic Clinical Data System includes data from administrative claims, electronic health records, case management systems, health information exchanges, and clinical registries. Next slide.

The denominator for this measure is beneficiaries with at least two antipsychotic medication dispensing events of the same or different medications on different dates of service during the measurement year. The numerator for this measure includes beneficiaries who received at least one test for blood glucose or HbA1c during the measurement year. Beneficiaries who received at least one test for LDL-C or cholesterol during the measurement year, and beneficiaries who receive both the following during the measurement year, on the same are different dates of service, at least one test for blood glucose or HbA1c and at least one test for LDL-C or cholesterol. The current technical specifications for the measure include only stratifications by age and product line. Measure steward notes that this measure is under review for potential race and ethnicity stratifications for measure year 2026, which corresponds to the federal fiscal

year 2027 Core Set reporting. This measure has not been identified by CMS for mandatory stratification for federal fiscal year 2025 Child Core Set reporting. We would like to highlight that the measure steward changed this measure to an Electronic Clinical Data Systems only measure for HEDIS measure year 2024, which corresponds with Core Set federal fiscal year 2025.

Previous versions of this measure allowed for data collection via administrative or electronic clinical data system methods. Workgroup member who suggested this measure for addition stated that there are gaps in the measures on the 1945 and 1945A Health Home Core Set that focus on integrated primary care and behavioral health. The Workgroup member also noted that antipsychotic medications can elevate a child's risk for developing serious metabolic health complications. I now like to hand it back to Tricia to facilitate our Workgroup member discussion of the Metabolic Monitoring for Children and Adolescents on Antipsychotics or APM measure. Okay.

Patricia Rowan:

Okay. Thanks so much, Kalidas. So, before we kick off the Workgroup discussion, I do just want to mention that we will be voting separately on adding this measure to the 1945 Core Set and the 1945A Core Set. So, as you're thinking through the discussion and as you ask questions or make comments, if your thoughts or comments are different for the two different Core Set, please make that distinction. And just as a reminder, 1945A is the state plan option for children with medically complex conditions. So, at this point anyone who has comments or questions about the APM measure, please feel free to raise your hand and we'll kick off the discussion. Ari.

Ari Houser:

So given that we just declined to recommend a similar measure for the adult population, I'd be interested in hearing from the measure steward or anyone else on the call what argument there is for inclusion of this measure for children, given that we are not including a somewhat comparable measure for adults.

Patricia Rowan:

Sorry. As others want to comment on Ari's question, feel free to raise your hand and get in the queue. I see Sara.

Sara Toomey:

Hi. I guess I'll partially address Ari's question. At least in my mind. I think this is different in a number of ways. I think if you look, and I'm going to speak specifically, to 1945A, you know, there is not actually much covering sort of the patients with psychiatric illness. Antipsychotics are used quite broadly in pediatrics for a really all sorts of different conditions from autism and aggression to bipolar and schizophrenia. But they're much more broadly utilized. And they are -- and pediatrics in particular, and I'm sure this comment would also hold for adults, but they're considered from my perspective, be a vulnerable population. And knowing that they're starting as children sort of screening for sort of metabolic sort of derangement is really a necessary component to their treatment. At least for me, that would be a rationale for why one might vote for this while the other was not voted up.

Patricia Rowan:

Thanks, Sara. Amy.

Amy Houtrow:

Hi everyone. This is Amy Houtrow. You know, to Sara's point, the issues around the broad use of these medications in pediatrics, the potential long-term impact on their health well into adulthood by missing the opportunity to do the testing. And the lower likelihood that treating clinicians are really attentive to cholesterol and blood glucose testing among children, I think is something for us to consider as a group.

Because while this kind of testing is very common in routine parts of standard of care for adults, isn't always the case that children are getting cholesterol testing. And so, from a perspective of how does this differ from something that we would -- just said no to for adults, is that I think there's some differences in the prescribing practices for the antipsychotics. The differences in how children are routinely screened and differences in terms of preventing lifelong complications of diseases related to metabolic syndromes.

Patricia Rowan:

Thanks, Amy. Pamela.

Pamela Tew:

Hi. I think there's a lot of -- sorry about that -- a lot of reasons why this measure is important. And I would say, you know, there -- seems to be a rise in off-label usage and not always in conjunction with therapy or follow up for members or for patients that are put on medications that would put them at higher risk. And you know, earlier there were discussions about prevalence. And while the prevalence might be lower than the general population because of the risk of chronic conditions of coronary artery disease and diabetes down the road.

And with diabetes being the seventh leading cause of death, and then the other with all mental health diagnoses being at around 50 percent, which I think that data's a little bit older, and my suspicion is that it would be higher now than it was then, that the cost -- the potential cost increase by not doing the screening and ensuring that we're keeping people healthy and monitoring them and providing health promotion as was discussed earlier, will really help this population stay healthy and have much better outcomes and have a great impact on the total cost of care for members.

Patricia Rowan:

Thanks, Pam. Jeff.

Jeff Schiff:

I'm really appreciating this conversation and specifically the parts around the off-label use of anti-psychotics and the fact that this measure seems to be agnostic to the diagnosis. And I'm having some tension between that and, you know, you guys bringing up the issue of us voting separately on 1945 and 1945A. Partly because 1945A doesn't actually exist in practice yet anywhere. And I'm just trying to figure out if I was a state wanting to start a 1945A program, not

that one measures a big burden, but how much measurement burden we want to put on a state around something, you know, where this is -- where we're just trying to get states potentially interested in these kids or at least understand why they're not interested, which can relate to its financing.

So, I'm really intrigued with this in 1945. I'm a little less intrigued than 1945A, not because I don't think it's important, but because I think we ought to give 1945A a chance to be born and then maybe come back and say, "Well, now that it's born, we can see what kind of programs are existing for kids and whether this is a big enough denominator of kids on anti-psychotics to consider this measure." So, thanks.

Patricia Rowan:

Thanks for those comments, Jeff. Kim.

Kim Elliot:

I appreciate that, Jeff. That's really thoughtful feedback. One of the things that I think about with this measure as well is that it is an ECDS measure. So, the data sources are a little bit different than some of the others, such as use of case management records and things like that. So that can increase resources a little bit as well. But the impact it can have on children, and I agree with Jeff, that 1945A, it's a stronger benefit, I think, for that particular program than the 1945. But that's just my opinion. Thank you.

Patricia Rowan:

Thanks, Kim. Other comments on this measure? All right. I am not seeing any other Workgroup hands raised to make a comment on this one. So why don't we go to the next slide. Provide an opportunity for public comment on this measure. Again, if you are a member of the public, please use the Raise Hand feature in WebEx and then state your name and affiliation before making your comment. And again, we are discussing the Metabolic Monitoring for Children and Adolescents on Antipsychotics. I am not seeing any hands raised. So again, before we move to a vote, I want to give one final opportunity to make comments or ask questions about the Metabolic Monitoring for Children and Adolescents on Antipsychotics Measure or APM. As the opportunity for Workgroup members, federal liaisons, members of the public to make a comment or ask a question.

All right. Well, let's get back to voting. I'll let Emily pull up the Slido. While she's doing that, I will note again that the Workgroup will vote twice on this measure. The first vote will be whether to suggest the addition of Metabolic Monitoring for Children and Adolescents on Antipsychotics to the 1945 Health Home Core Set. And the second vote will be for the 1945A Health Home Core Set. So, the vote that's active now is for addition to the 1945 Health Home Core Set. Just as a reminder, 1945A is for children with medically complex conditions. So, this vote is for 1945 Health Homes, which are the traditional health home programs. All right. We're expecting 13 votes and I see 13 votes. So let us just confirm we have everyone. All right. Voting is now closed. We can share the results. All right, 54 percent of the Workgroup voted yes. That does not meet the threshold for recommendation.

So, the Metabolic Monitoring for Children and Adolescents on Antipsychotic measures is not recommended for addition to the 2026 1945 Health Home Core Set. Now, we will move on to the next vote, which is a vote to recommend the measure for addition to the 1945A Health

Home Core Set, which is again, for children with medically complex conditions. This is voting on the same measure, Metabolic Monitoring for Children and Adolescents on Antipsychotics, whether to recommend the measure be added to the 2026 1945A Health Home Core Set. All right. Let us confirm that we have everyone's votes. Okay. We have all the votes we are expecting. Voting is closed. We can share the results. All right, 54 percent of the Workgroup voted yes. That does not meet the threshold for recommendation.

So, the Metabolic Monitoring for Children and Adolescents on Antipsychotic measure is not recommended for addition to the 2026 1945A Health Home Core Set. Thanks everyone for your engagement in the conversation and your voting. All right. That brings us to the end of our measure discussions today. So again, I appreciate everyone's robust input and engagement, all of your contributions, and we look forward to the measure discussions tomorrow. Let's go to the next slide. One more. Thank you.

All right. So let me preview our agenda for tomorrow's part of the meeting. We will discuss one additional measure that was suggested for addition to both the 1945 and 1945A Health Home Core Sets. That measure is Social Needs Screening and Intervention. We will follow voting with a discussion on gaps in the Health Home Core Sets and transition to a Public Call for Measures for the 2027 Health Home Core Sets. We will end our annual review with an opportunity for reflections and discussion of future direction. And as always, there will be opportunities for public comment. We will begin promptly at 11:00 AM tomorrow Eastern Time and ask Workgroup members to, you know, sign in a few minutes early just like you did today. We really appreciated everyone being prompt returning from the break on time, engaging in the voting, et cetera. You guys make these meetings easy to run. So, before we close out, Kim or Jeff, do you have any final remarks to close out today's meeting? Kim, would you like to start?

Kim Elliot:

Sure. I'm happy to start. First off, I'd just like to thank all of the Workgroup members for their active participation in today's measure discussion. It was really clear that everybody came really well prepared and the subject matter expertise that everyone brought today to the discussion, it impacts me and how I think about some of the measures and I'm sure it does others as well on the Workgroup.

And I do really appreciate all of the time and effort that everyone takes in preparing for the call. And I think it really does lead to some really good decisions and recommendations to provide to CMS on either adding or deleting, in this case, adding measures to the Core Set. But in particular the impacts that it would have the states or those that are involved in the core measures that -- whether it's from the implementation standpoint or even the participants themselves, the members and the impacts to them. So, I want to thank everybody for everything in today's call. And I'm looking forward to tomorrow's.

Patricia Rowan:

Thanks Kim. Jeff.

Jeff Schiff:

Thanks for the hard work. I want to just say -- as I said in the beginning, I'm looking forward to this gaps conversation and hope we all think about the slide that looked at this, you know, there're three levels and this is being the middle level for program and what our gaps are in this

level. It's different than the Core Set overall because this is really a program focused on coordinating care for beneficiaries. So, I'm looking forward to -- I hope some of you will have good dreams about measure gaps that you're crossing. So, I look forward to the conversation tomorrow.

Patricia Rowan:

Thanks, Jeff. I thought it was only me that dreamed about the Core Sets. All right. Well, again, thanks everyone for coming and being part of today's meeting. We wish you all a lovely afternoon. This concludes Day 1 of our 2026 Health Core Sets Annual Review Meeting. So, we will adjourn now and see you all tomorrow. Thanks again, everybody. Bye-bye.