Mathematica 2026 Health Home Core Sets Annual Review:
Meeting to Review Measures for the 2026 Health Home Core Sets Day 2 Transcript
June 26, 2024, 11:00 a.m.- 2:30 p.m. ET

Maria Dobnick:

Hello, everyone. My name is Maria Dobinick, and I am so pleased to welcome you back to the second day of the Medicaid Health Home Core Sets Annual Review Meeting to Review Measures or the 2026 Health Home Core Sets. Before we get started today, we wanted to review the technical instructions. Next slide. If you have any technical issues during today's meeting, please send a message to All Panelists through the Q&A function located on the bottom-right corner of your screen. If you are having issues speaking during Workgroup or public comments, please make sure you are also not muted on your handset 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. So, if you would like to make a comment today, please be sure that your audio is associated with your name on the platform.

Next slide. All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and the public to make comments. To make a comment, please use the Raise Hand feature in the lower-right corner of the Participant Panel. A hand icon will appear next to your name on the Attendee List. You will be unmuted in the order in which your hand was raised, so please remember to lower your hand when you have finished speaking by following the same process by which you used to raise your hand. To make another comment, please re-raise your hand; and the host will unmute you again. Note that the Chat is disabled for this meeting. Please use that Q&A feature if you need support. Closed captioning is available in the WebEx platform; and to enable the 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. With that, I'll hand it over to Tricia Rowan to get us started.

Patricia Rowan:

All right, thanks, Maria. Let's go to the next slide. Well, welcome back, everybody. Thanks for hanging in with us again for Day 2 of the 2026 Health Home Core Sets Annual Review Meeting. Everyone, I hope you had a good afternoon and evening yesterday and are ready to reengage in today's discussion. I'll do a quick overview of the outcome of yesterday's conversation. The Workgroup discussed two measures for potential addition to the 2026 Health Home Core Sets. The first was the Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications or SSD. That measure was suggested for addition to the 1945 Health Home Core Set, and it was a measure that assessed the percentage of beneficiaries who have schizophrenia, schizoaffective disorder, or bipolar disorder and the frequency with which they received diabetes screening within a measurement year.

The Workgroup discussed the importance of that measure for an at-risk population and the complications associated with individuals who have co-occurring behavioral health issues and diabetes, but raised concerns about the level to which Health Home programs might impact screening rates performed by other providers and the appropriateness of the measure for the Health Home Core Set. Ultimately, the Workgroup did not recommend that this measure be added to the 2026 1945 Health Home Core Set.

The second measure that was discussed yesterday was Metabolic Monitoring for Children and Adolescents on Antipsychotics or the APM measure. That measure was suggested for addition

both to the 1945 and 1945A Health Home Core Sets, and it's somewhat similar to the SSD measure but focuses on children and adolescents who have two or more antipsychotic prescriptions and receive metabolic testing; and it's not submitted to children or adolescents with a specific diagnosis.

The Workgroup discussed the differences between this measure and the previous measure discussed, and several Workgroup members highlighted that this measure may be appropriate for addition due to increased risk for a pediatric population and the long-term implications of potentially not monitoring metabolic rates for children who are on antipsychotic medications, particularly in light of some off-label prescribing practices within that population. Ultimately, the Workgroup did not vote to recommend this measure for addition to the 1945 or 1945A Health Home Core Sets.

So, we're looking forward to another day of discussions about the Health Home Core Sets of quality measures. Today we will discuss one final measure that was suggested for addition around social needs, screening and interventions. Then, we will discuss gaps and future directions for this Committee and the review process.

Before we begin, let me invite our Co-Chairs to welcome us and kick off today's meeting. Kim, we started with you yesterday; so maybe, Jeff, we'll start with you today if that's okay.

Jeff Schiff:

(Inaudible) save some stuff to say. I'm looking forward to looking at this measure; it's a different sort of measure. I'm also looking forward to a great conversation about the gaps because I think we have an opportunity to think about how the gaps affect this program and also how we serve the population of adults and children who would qualify for health home. So, let's get this show on the road, thanks.

Patricia Rowan:

Thanks, Jeff. Kim?

Kim Elliott:

Yesterday discussing these diabetes screening measures for the health home medications, particularly for those that are on medications that really increase their risk for diabetes. And I really appreciate the thoughtful discussion on the value to the Core Set as well as the value to the member from a quality perspective. Quality of life/quality of care -- I kind of bucket them together when we're talking about core measures.

I'm also anticipating that today we will also keep the member as the focus of why we measure performance and the measures that we include in the Health Home Core Sets. It really is kind of a balancing exercise of feasibility/viability amongst many other factors. Today, in addition to one more measure under consideration that we'll be discussing, we're also going to be talking about gaps. I really love the gap discussion, and I think that's a format that Mathematica uses that's really great to really draw out some good ideas from all Workgroup participants to really close those gaps and improve care, service, outcomes for those served in the health home program. So, I'm really looking forward to our work today. Thank you for your continued focus and participation throughout the meeting. Everyone's viewpoints and experiences really enjoy as we discuss these measures. So, thank you again. I'm looking forward to today.

Patricia Rowan:

Thank you, Kim and Jeff. Let's go to the next slide. So now we'll do a quick roll call of the Workgroup just to make sure everybody is here. Next slide.

We ask that Workgroup members use their Raise Hand feature in WebEx to be unmuted during the introductions. Then after that, you can mute yourself locally. That will allow you to mute and unmute a little more easily during the day. If you do have to exit and reenter the WebEx platform, just use the Raise Hand feature, again, and we can unmute you. Next slide. On these next couple of slides, we've listed the Workgroup members. So, when I call your name, please raise your hand; and we will unmute you. We've already heard from Kim and Jeff, so we'll start with David.

David Basel:

Good morning, looking forward to Day 2.

Patricia Rowan:

Thanks for being here. Macy?

Macy Daly:

Hi, everybody, nice to see you all. This is Macy Daly from Rhode Island.

Patricia Rowan:

Thank you. Ari? I wonder if we lost Ari. Ari, are you there? Can you unmute?

Ari Houser:

Ari Houser, take two, hopefully my audio is working this time.

Patricia Rowan:

Yep, you sound great.

Ari Houser:

Great, thank you.

Patricia Rowan:

Amy?

Amy Houtrow:

Hi, everyone. This is Amy Houtrow, glad to be here.

Patricia Rowan:

Thanks for being here. Pamela Lester? Pamela, can we try your audio again?

Pamela Lester:

Oh, yep, sorry. I said hello. Welcome, everybody. It's great to be here, Pam Lester. Sorry.

Patricia Rowan:

No problem, I think that was an issue on our end. Next slide. Libby?

Elizabeth Nichols:

Good morning. This is Libby Nichols.

Patricia Rowan:

Hi, Libby, thanks for being here. Kayla Romero? Kayla, are you able to hear us?

Kayla Romero:

Yes, can you hear me?

Patricia Rowan:

Yes, we can hear your audio, thank you. Pamela Tew?

Pamela Tew:

From ZERO TO THREE.

Patricia Rowan:

Great, thanks for being here. I think we unmuted you a little late, so we didn't hear your first name. Thanks for being here, Pamela. Sara Toomey?

Sara Toomey:

Hi, this is Sara Toomey, happy to be here.

Patricia Rowan:

Thanks, Sara. Laura Vegas? Laura, are you there?

Laura Vegas:

Yes, can you hear me?

Patricia Rowan:

Yes, now we can hear you.

Laura Vegas:

Sorry about that. Good morning, everyone. This is Laura Vegas from NASDDDS. Glad to be here today.

Patricia Rowan:

Awesome, thank you for being here. Jeannie Wigglesworth? Do we have Jeannie? Go ahead, Jeannie. Jeannie, we are not hearing you. Can you--?

Jeannie Wigglesworth:

Oh!

Patricia Rowan:

Oh, there we go.

Jeannie Wigglesworth:

You can hear me now, I'm sorry. This is Jeannie. I'm Jean Wigglesworth, here from Connecticut.

Patricia Rowan:

Awesome, thanks for being here. That's why we do the roll call because the unmuting and muting is the hardest part of the meeting sometimes. Thanks for being here, everybody. We are looking forward to your contributions today. I appreciate you joining us for the second day of the meeting. Next slide.

So, as I mentioned yesterday, we are enjoining five federal liaisons who are non-voting members of the Workgroup. Federal liaisons, if you have any questions or contributions during today's discussion, you also can use the Raise Hand feature; and we will unmute you. As always, I want to take an opportunity to thank our colleagues in the Medicaid Benefits and Health Programs at the Center for Medicaid and CHIP Services; and also, the measure stewards who are attending and available to answer questions about their measure. All right, next slide.

We will start off today with our third and final measure that has been suggested for addition. I'm going to hand it over to my colleague, Maddy, to walk us through this measure. Maddy, go ahead and take it away.

Madelaine Spiering:

Thanks, Tricia. Next slide, please. The final measure suggested for addition that the Workgroup will discuss this year is the Social Needs Screening and Intervention. This measure was suggested for addition to both the 1945 and 1945A Health Home Core Sets. This measure is defined as the percentage of members who were screened using prespecified instruments at least once during the measurement period for unmet food, housing, and transportation needs *and* received a corresponding intervention if they screened positive.

Six rates are reported: First, the food screening rate measures the percentage of members who were screened for food insecurity. Two, the food intervention rate measures the percentage of members who received a corresponding intervention within 30 days of screening positive for food insecurity. Three, the housing screening rate measures the percentage of members who were screened for housing instability, homelessness, or housing inadequacy. Four, the housing intervention rate measures the percentage of members who received a corresponding intervention within 30 days of screening positive for housing instability, homelessness, or

housing inadequacy. Five, the transportation screening rate measures the percentage of members who were screened for transportation insecurity. Finally, six, the transportation intervention rate measures the percentage of members who received a corresponding intervention within 30 days of screening for positive for transportation insecurity. NCQA is the measure steward, and this is a process measure. It was *not* recommended to replace any current measures.

Next slide. The data collection method is HEDIS Electronic Clinical Data Systems or ECDS. As we mentioned yesterday, ECDS includes data from administrative claims, EHRs, case management systems, health information exchanges, and clinical registries. The denominator for each of the screening rates includes members of any age and roles at the start of the measurement period who also meet criteria for participation. Participation includes both allocation and continuous enrollment criteria, which are shown on the next slide. The denominator for each of the three intervention rates includes members with a positive screen finding in the respective domain between January 1 and December 1 of the measurement year.

Next slide. Here you can see the allocation and continuous enrollment criteria for inclusion in the screening rate denominators. This slide also shows the numerator definitions for five of the six measure rates.

Next slide. The numerator definitions continue on this slide. We want to note a few things about the numerator requirements. First, screening numerators count only screenings completed using one of the instruments included in the measure specification. We have provided the list of eligible screening instruments in the Measure Information Sheet, and only screenings documented using the LOINC codes in the measure specification count towards the measure screening numerators. For the intervention numerators, the intervention provided must correspond to the type of need identified; and interventions may include any of the following categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral. The HEDIS measurement year 2024 specifications include stratifications by age group for the Medicaid product line. NCQA noted that they considered other stratification categories during measurement testing but determined that this was not feasible either because the denominators were too small to stratify, or the test data did not include the necessary data elements. NCQA has also indicated that they are working to update the measure to add utility insecurity as a fourth domain. They expect this update to go into effect for HEDIS measurement year 2026, which corresponds to the 2027 Health Home Core Sets. As a reminder, the Workgroup *will* vote on the measure as currently specified; that is, without the utility insecurity domain.

The Workgroup member who suggested this member for addition acknowledged that the data collection could be challenging as only specific instruments to assess social needs are included in the measure, and some of the measure specification used LOINC codes which have been historically challenging for some states to collect and use. However, the Workgroup member notes that there has been much improvement in data collection, particularly due to the increase in utilization of alternative sources such as case management systems. The Workgroup member also commented that this measure involves a newer area for measurement for the Health Home Core Sets; however, the issue itself is not new. Health plans have consistently, and with increasing frequency, been working on health-related social needs to improve care and service delivery and outcomes for members. Because it is a new measurement area for the Health Home Core Sets, there is a significant room for improvement. With that, I'll hand it back over to Tricia to lead our Workgroup conversation around this measure.

Patricia Rowan:

Great, thanks, Maddy. Let's go to the next slide. Let's go to the next slide. Okay, well, like we did yesterday, we will start with Workgroup comments and remarks about this Social Needs Screening and Intervention measure. So please raise your hand, and we will unmute you in the order that your hand was raised. We do have representatives from NCQA on the line if there are any questions about the measure specifications. Also, like yesterday, I want to be clear from the beginning that we will be voting twice for this measure; first for its addition to the 1945 Health Home Core Set and, second, for addition to the 1945A Health Home Core Sets. I see Jeannie ready to go. Let's start with Jeannie.

Jeannie Wigglesworth:

Hi, I just had a question about what you said about the LOINC codes. Could you repeat that? I thought I heard that we can only screen using LOINC codes could be used for the numerator, but I think I misheard that. So, I was just wondering if you could repeat what you said regarding the LOINC codes.

Patricia Rowan:

Yeah, absolutely. Maddy, do you want to take that one? Should we go back to the previous slide?

Madelaine Spiering:

Sure, I think that that was on slide 14. We said -- we provided the list of eligible screening instruments in the Measure Information Sheet, and only screenings documented using the LOINC codes in the measurement specifications counts toward the measure screening numerators.

Jeannie Wigglesworth:

So, you can only use LOINC codes? Is that what you're saying?

Maria Dobinick:

So, I will step in here and clarify really quick that it is not all of the screenings that have them. So only some of the specific screenings use the LOINC codes, and it is outlined in the technical specifications which codes are associated with which screenings.

Jeannie Wigglesworth:

Okay, thanks for clarifying.

Maria Dobinick:

Yeah, absolutely.

Patricia Rowan:

Jeannie, did you have any other questions or comments on this measure?

Jeannie Wigglesworth:

Not at this moment, no, thanks.

Patricia Rowan:

Great, I see Ari with their hand up. Ari?

Ari Houser:

Hi, conceptually I like this measure; and I particularly like it for health homes, which are programs that really, I think, *should* be connecting people who need social services to those services. I do have a couple of concerns, and I wanted to give the measure stewards or anyone else on the call some opportunity to help us assuage those concerns because I would like to get to "Yes," but I'm not there yet. The main one is that this is a measure that in large part is measuring are you using one or more of these set of tools, when the goal is are you connecting members to social services that they need. And I'd be interested in seeing any studies on the validity of that measure to that goal. Have we looked at programs using these tools and are those programs -- is there a reasonably strong relationship between using these tools and better connecting members to the social services that they need? And that seems to be -- that evidence, to me, seems to be a crucial link. If this measure is to be recommended, we need to see that is actually not just measuring the use of the tools but actually getting to the end goal. That's certainly plausible to me, but I would like to see it in the data if that's available, has that been done. The second lesser concern is, is the amount of technical service and other assistance needed going to be burdensome to the extent that it is problematic to include at this time?

Patricia Rowan:

Ari, thanks so much for those thoughts. I see a couple people with hands up who may want to respond. Kim, do you want to go first?

Kim Elliott:

Sure, so when I read the measure description, the use of the screening tool is because they are tested and validated tools. So, they want to make sure that for this measure that the screening is conducted using something that has already been tested and found to be somewhat effective. But it also requires that once you do that screening that the member receive the corresponding intervention if they screen positive for any of the things like food, housing, transportation, et cetera. So, it isn't just a measure that is trying to determine if you're using a screening tool or a specific screening tool. It's also the follow-on component of making sure that if they screen positive that there is an intervention associated with that positive finding. So that's one of the reasons I kind of like this measure.

But I also think -- thinking back to when I worked at a health plan and also when I worked for a state Medicaid program, some of the things that we would often see are members that didn't necessarily have a place to get food on a weekend or housing on a weekend. So, they would either call 911 or some social interaction, or they would show up in the emergency room so that they would have that meal or that hot place to stay if it was cold, something like that.

These are the things that I think tie really nicely in with health home and the care coordination aspect of it to make sure that you are screening -- the health homes are screening and

connecting them to services. But those are the reasons I really like this measure. It kind of starts getting to the root of identifying and addressing those sorts of social issues.

Patricia Rowan:

Thanks, Kim. Ari, I don't know if Kim kind of answered your question. I also want to point out that we do have Adrianna and Kalina from NCQA here, which is the measure steward. Ari, go ahead.

Ari Houser:

I'm sorry, I didn't mean to unmute. But, yeah, I actually -- I want to see the validation studies. It certainly is plausible to me that the use of these tools has a meaningful relationship to doing better on the outcomes that we care about, but I need to see the evidence before I vote for it. I think that's -- and I'm not even sure that evidence of that sort is available. I can't tell from the write-up. But even if it is, I would want to see it before I vote on it.

Patricia Rowan:

Thanks, Ari. Adrianna or Kalina, is there anything you would like to add to the discussion? Adrianna, I see you have your hand raised, go ahead.

Adrianna Nava:

Adrianna from NCQA. I just wanted to add that in some of the work when we've been working with health plans and even just speaking with delivery systems, there's been a lot of screening tools that are grown within the organization. People are pulling different types of tools. So, one of the goals with our measure is to make sure that we create standardization of what types of tools, and of course the tools are based on best practice and evidence-based tools in the literature. We've worked closely with the Gravity Project, which also had experts convene and went through the screening tools as part of their process to be able to identify which screening tools would be able to have LOINC codes available and be coded appropriately, which then we consulted with in order to build our measure.

So really being able to begin to see how we can pull together data related to social needs and create structured fields so we can be able to collect this data since a lot of it is usually with a narrative format and starting to move the needle in terms of trying to be able to collect this data was important and a reason for the need for this measure to be developed in order for us to be able to standardize hospitals who need data being collected through the screening tools.

And as mentioned by Kim earlier, we do have that second component which is the intervention indicator. So being able to see that those that have screened positive using validated tools are receiving some type of intervention is also a way for us to be able to start to pull that structured information. There are ways to improve this measure, as we've acknowledged that follow up once that intervention is done. It was there to close the loop follow up that we can then determine whether or not this is actually leading to improvements in addressing social needs because that is something that we are acknowledging that we are working on down the line.

In terms of the validity testing, we are conducting that with our first-year analysis. This measure is collecting information this summer from health plans to see the feasibility of collecting this information. So, we will have additional analyses to provide, but that will be conducted this summer.

Patricia Rowan:

Thank you, Adrianna. Jeannie, I see you have your hand up.

Jeannie Wigglesworth:

Hi, there. I just wanted to go back to the LOINC code question again. In Connecticut, I mean I'm associating LOINC codes typically as lab data or lab values; so, I'm a little confused as to where the LOINC codes play into this metric.

Patricia Rowan:

Adrianna, is that something you can speak to? Derek, can we unmute Adrianna? There we go, thank you.

Adrianna Nava:

Yes, so each of the screening tools have been mapped to a LOINC code so that LOINC code is associated with a specific question. So, we will be able to determine what question was asked and how it aligns with which data tool or survey tool it came from. So traditionally, they are lab codes; but there are LOINC codes also associated with the screening tools, and usually they live in the EHR data.

Patricia Rowan:

Okay, so they're specifically -- they were specifically created for these tools?

Adrianna Nava:

Correct.

Patricia Rowan:

Okay.

Adrianna Nava:

So, we can link it back to the specific question. So, we would be able to look at that LOINC code and see what question was asked.

Patricia Rowan:

Perfect, thank you for clarifying that.

Adrianna Nava:

You're welcome.

Patricia Rowan:

Jeff, I see you have your hand up. Derek, can we unmute Jeff?

Jeff Schiff:

I think we're both trying to do the same thing.

Patricia Rowan:

There we go, okay.

Jeff Schiff:

I just want to ask a couple of clarifying questions if I can. The intervention list includes education referral. Are those separately tracked individually, or are they is it, is once the person is identified as having a food insecurity or housing insecurity you just check that an intervention is done?

Patricia Rowan:

Adrianna, sorry to keep putting you on the spot; but I'm going to let you take these questions. Go ahead.

Adrianna Nava:

So, each intervention does have a SNOMED code or a CPT code that is associated with it. So technically, we would be able to see what the intervention was; but in terms of the performance scoring that's given, it would be aggregated. So as long as they did some sort of intervention, it would count; but we would be collecting what that intervention was via the SNOMED code or a CPT code.

Jeff Schiff:

And like the -- I think Ari's comment on the validation of the tools, is there any sort of validation or information about the interventions as they've been studied so far?

Adrianna Nava:

As they've been studied so far, yes. The Gravity Project does -- their team of experts have used interventions that have been associated with addressing, for example, food insecurity or inadequate housing and then we work with Gravity Project to pull those data elements over into our measures.

Jeff Schiff:

Okay, and do we have an understanding of like most of these are referrals or most of these are education or most -- which of those lists of interventions are the most commonly used?

Adrianna Nava:

So, we're doing our first-year analysis this summer so we would have a better idea of what in fact what is actually used. But in terms of each domain, it pretty much varies. We've been speaking with health plans, many of whom are looking at referrals. So, referring them out to community services tends to be something that is talked about a lot. But we would have to wait till our first-year analysis -- in terms of in fact what is actually happening. But in terms of what the Gravity Project has put together, it's pretty diverse depending on the domain.

Jeff Schiff:

Got it, thanks.

Adrianna Nava:

You're welcome.

Patricia Rowan:

Thanks, Jeff and Adrianna. David, I see you have your hand up as well.

David Basel:

Thank you. So, a couple of categories of comments. First off, this is obviously a hugely important area to move forward in as far as screening and intervening for social determinants. I think most people agree with that. Mine are mainly questions around pacing and alignment. So, as I spoke yesterday, it concerns me adding in new measurement requirements without taking anything else away that will dilute the efforts of everything else. But I do think this very well could be something -- a priority that would warrant doing that, but we should be very discreet about doing that.

The other kind of categories -- I do sit also on the Medicare and Medicaid Pre-Rulemaking Measure Review Committee, where we've spent quite a bit of time discussing these metrics for inclusion in Medicare quality value programs. In that setting, there's kind of three main steps to the pacing of that. The first is measuring did you screen for it. Then the second step is are we measuring -- did you refer that agent to a community or governmental agency. Then the third step is did they do an intervention that successfully closed the social needs gap. At this point in the other Medicare programs, only in the hospital setting only has the screening metric been moved over. We're all expecting that in the future that we'll be moving forward for the referral and intervention pieces of this, but the recognition of how significant of a lift to be able to track and report on these is a significant change and a significant burden to have to do and will take years to get us to that point. So, from an alignment and a pacing standpoint for this group to kind of jump several steps of that process ahead of everywhere else, I just think it's too early and definitely think it's worth discussion, definitely think it's the way we're heading. We want to get any type of reasonable data out of it at this point and probably need to wait a little bit in my opinion, thank you.

Patricia Rowan:

Thanks, David, for those comments. Other comments or discussion on this measure from the Workgroup? Jeff, go ahead.

Jeff Schiff:

I just want to say some things that are -- I had asked some clarifying questions, but I think I'm with David on sort of not ready for this level of raising this to this level by including it at this point. A couple reasons I want to just talk about. First, I just really want to say that we all would love if all Medicaid beneficiaries with or without health home needs had adequate housing, food, and transportation. But one of the projects I'm involved in, which is a HRSA-funded project with kids with medical complexity who would be 1945A-type kids, families talked about financial things in general; but they also talked about other risk factors for them, which may be like things

like access to care and the time that's necessary to provide care and their own feelings of inclusion. So I feel like if we go down this road with what are essentially economic parameters, we may miss the opportunity to intervene on some other things that we may have more direct input on. So, I don't think we're quite there yet as far as that's concerned.

Then my other concern is I think David brought up we have the screening and the referral here, but we don't really have a closed loop to see whether or not the intervention was successful. I think families in my clinical life -- we've done some of these, albeit not standardized tools. In two incidences, we stopped doing the screening because we thought folks felt like really, we're asking the questions -- the beneficiaries were asking questions, "Are you doing this for surveillance, or are you doing this to help me?" So, I think we have to be really clear that we have pulled this thread all the way through to intervention that makes a difference before we do a measure that just does part of that. I think I'll stop there, thank you.

Patricia Rowan:

Thank you, Jeff. Amy, I see you have your hand up.

Amy Houtrow:

Yes, this is Amy Houtrow. So, I heard that the system isn't quite ready to handle this kind of measure, and then we also just heard Jeff say that the measure might not take it far enough. So, I think it's more like a philosophical question of how do we get ready to be able to do something if we don't make the system do it? And if it doesn't take it far enough, I think we would have the same argument -- well, there's no possible way the system is ready for it because we haven't been doing any of the preceding things. So, this is more of a "how do we move the field forward" kind of question.

I think oftentimes it's by requirement of doing something that things change. So, I'm wondering what people's thoughts are taking it from *that* vantage point versus like the kind of challenge that it poses right now. I similarly agree there's a lot of things that this doesn't cover; but it also covers some really impactful and important things, and I wouldn't want perfect to be the enemy of the good.

Patricia Rowan:

Thanks for that, Amy. Libby?

Elizabeth Nichols:

Amy, I really liked your comments; and I think I've kind of been thinking along those lines too. This measure, while we may have like hopes and dreams of a perfect measure, this measure is available and at least helps get that process -- shines a light on that as a process measure and trying to encourage it. I think for me where the balance is, is that this would be mandatory if it was on the Core Set. I think the other piece of it is we would have to have enough information about the expected measure performance to know what are the pieces that need to change to troubleshoot. I think my concerns are just that because the measure is so new that we haven't had enough time to even know how to troubleshoot the measure. In my mind, I'm almost like next year. That's sort of where I'm at -- is I'd like to have the data -- have the measure be meaningfully used.

It sounds like NCQA is actively doing great validation work that would be super informative; and if we're going to make something mandatory, I'd like to be able to also have some very light signposts of how to help folks get to where they need to be. And I'm worried that we're like just a little bit too early for those things to become apparent yet. So, I echo your thoughts that sometimes making something mandatory is the way to go in that direction and also that sometimes doing something is better than waiting for the perfect thing. I really like this, measure, and I think it's so important that this be accounted for in health homes. What I'm worried about is just if we make it mandatory and we don't totally have a way of understanding where the friction is or where the tough points are and how to navigate those with a new measure that's relatively different in its kind of data collection and system use and that maybe just having another year or two under the belt would be *incredibly* helpful if we're making it mandatory. So that's sort of how I'm navigating those questions, Amy; but I have a lot of the same ones.

Patricia Rowan:

Yeah, thanks, Libby. I think your comment and Amy's both do a really nice job of elucidating the balance between the desirability of a measure and the feasibility of a measure, which of course is that the balance that his Workgroup is charged with navigating. Something I do want to clarify is last year you might recall -- well, let me just clarify the time period because last year we made a decision in partnership with CMS to kind of jump a year ahead. So, you're probably -- all of the materials for this meeting talk about the 2026 Health Home Core Set. The 2026 Health Home Core Set would be reported in September 2026, starting in the fall of 2026; and it would be for performance year which is generally calendar year 2025. So part of the reason we made this change in our review process is to give a little bit more of an onramp for states to plan and prepare and for CMS to provide technical assistance. So, I just want to just anchor everyone in the time period for the review and when the actual reporting would be done and become mandatory, just in case that changes anyone's considerations. I will stop there. If there are other comments and questions from the group, please use the Raise Hand feature.

Jeannie?

Jeannie Wigglesworth:

Hi, can I ask just a quick related question? As we move forward with the stratification requirements and also the requirement to include dual membership, I know that has been, I think, postponed for a couple of years. But can someone talk to me a little bit about commercial dual and Medicare dual? When we are expected to include duals in the future, are we including commercial as well; and then, how is that to be stratified as far as results since we are in year 2026-2025? Because I think that's when duals are expected to be reported in with the measure -- I believe.

Patricia Rowan:

Yeah, that’s a really good question, Jeannie. Sara Rhoades from CMS, do you want to take -- do you want to speak to stratification expectations for this? If not, I can take a stab at it. Sara, go ahead, you should be unmuted. Sara, are you there? Sara, we are not hearing you. I'm not sure if you're muted locally; or if not, well, we can come back to you.

Okay, Jeannie, my understanding is that the expectation would be to include all dually-eligible beneficiaries included in the population. There is information -- oh, go ahead.

Jeannie Wigglesworth:

No, no, I just said thank you.

Patricia Rowan:

And then I think there is in a recent maybe in the final rule for mandatory reporting, it does talk about the implementation runway for stratification. CMS, for example, identified a subset of measures that would be mandatory to stratify; and then each year, they would identify additional ones. I think there's a runway.

Jeannie Wigglesworth:

Yes, I saw that. They're going 25 percent each year, until full amount. Is that what you mean?

Patricia Rowan:

Yes, exactly.

Jeannie Wigglesworth:

So, with the duals though, are we reporting duals out separately from the Medicaid? Are we stratifying the duals, or you want them just included in the full number?

Patricia Rowan:

So far, they would just be included in the rates reported. Yes, one rate that is supposed to include the entire health home population, including those who are dually-eligible. CMS will release guidance each year on specifically the stratification and things like that.

Sara, if I'm talking out of school, feel free to pipe up. But it is not our understanding that there are current plans to stratify duals or report separately on duals as an individually population.

Does that help answer your question, Jeannie?

Jeannie Wigglesworth:

We go through a HEDIS audit too; and HEDIS, I think, does things a little differently. So, we always have to clarify, so that was very helpful. And this is for data year -- I always say "data year" -- 2025, right? So, calendar year MY 2026 but for the data year 2025, right?

Patricia Rowan:

Yes.

Jeannie Wigglesworth:

Okay.

Patricia Rowan:

Yep, that's correct.

Jeannie Wigglesworth:

Okay, yes, that was great. Thank you for clarifying that. I appreciate that.

Patricia Rowan:

Other questions or comments?

All right, well, I am not seeing any other hands raised from the Workgroup. Why don't we go to the next slide and provide an opportunity for public comment on the Social Needs Screening and Intervention measure. If you are a member of the public and you have comments or questions about this measure, this is the opportunity to share them. Just please use the Raise Hand feature in the WebEx panel, and we will unmute as hands are raised. Please remember to introduce yourself and state your name and affiliation before your comment. I am not seeing any hands raised, so let me do a final call for any comments or questions on the Social Needs Screening and Intervention measure before we move into voting.

Hi, I see someone -- Sarah -- on the line. Sarah, we can unmute you if you can just introduce yourself with your name and affiliation.

Sarah Brdar:

Yeah, I'm Sarah Brdar. I'm from Carelon Behavioral Health in Connecticut. I was just wanting to put out there that many of us who are using the NCQA measures as the NCQA measure stewards are having to separate out Medicaid and Medicare duals and Medicaid commercial duals and stratifying, especially for those NCQA measures, by those things, it would actually be easier versus harder for us. Putting them all together is more of a challenge.

Patricia Rowan:

Sarah, thanks for sharing that perspective. We appreciate it. Any other comments or questions on this measure before we move into voting? Yeah, I see someone with a call-in number. I don't know if that's Sara Toomey.

Sara Toomey:

Yes, it is; it's me, sorry about that.

Patricia Rowan:

That's okay.

Sara Toomey:

I just want to add in Massachusetts we're actually using this screening as part of our Mass Health waiver. So all of our health systems are having to implement this across our different systems, and I'm leading those efforts for my hospital. I guess I want to just say that on the one hand, I agree with Amy and others of the importance of this measure. I will say putting it in as a requirement has forced our hand to make a lot of changes, but I'll also say is I think it's really hard work and that there is -- depending on -- one thing in terms of it'll be interesting with NCQA's further validation is when one says that they've connected the person in part, there's a huge range and variability around what that connection can look like. So from the perspective of consistency across states in terms of what would be provided, this measure might have

unintended consequences of not actually helping people do as much as they can because they want to make sure that they're doing everything -- making sure they're doing something across the board that would count. Anyway, it's just a concern that I've had about it; and I'm worried a little bit for its used around public reporting, in particular when it could potentially have implications for payment.

But I do think that it has done, as Amy has said -- it does change people pretty quickly in terms of providing a platform for measuring -- collecting, measuring, stratifying -- along the very important health home social needs.

Patricia Rowan:

Sara, thanks for sharing that. I think your experience using the measure is super relevant, so really appreciate that. All right, other comments or questions from folks on the line -- either Workgroup members, federal liaisons, or members of the public?

All right, I am not seeing any more hands raised; so why don't we move into voting? As we do that, Emily, I'll let you pull up the Slido. Just like we did yesterday -- excuse me -- like we did yesterday, we will be voting on this measure twice. We'll start by voting on it for addition to the 1945 Health Home Core Set, and then we will move to voting for addition to the 1945A.

So, this first vote is for whether or not the Social Needs Screening and Intervention measure should be added to the 2026 1945 Health Home Core Set. As a reminder, 1945 Health Home programs are the traditional health home programs; 1945A, which we will vote on next, is for medically complex kids. We are expecting 12 votes -- or excuse me, 13 votes. We've got 12. Let us just take a moment to make sure we have what we expect.

All right, I see 13 votes. Let us first see we have everyone we are expecting before we share the results.

All right, we have received all the votes we are expecting. Voting is now closed, and we'll share the results. Wow, just reversed the order of the results. I was not expecting that. So only 15 percent of the Workgroup voted "Yes." That does not meet the threshold for recommending that the measure be added to the 2026 Health Home Core Set for 1945. So this measure does *not* meet the threshold for recommendation. We will move on to the next vote, which is whether the Social Needs Screening and Intervention measure should be added to the 2026 1945A Health Home Core Set. There we go. If you are not seeing the question active, please refresh your screen.

We are at 12 votes; we are waiting for 1 more. Just give us a moment to make sure we've got what we expect. If you are having any problems with voting, you can write to our team in the Q&A. Jeannie, we are missing your vote. Let us know if you need any help with the voting platform.

All right, voting is now closed. We will share the results. All right, so 15 percent of the Workgroup voted "Yes." That does not meet the threshold for recommend for addition. So, the Social Needs Screening and Intervention measure is not recommended for addition to the for the 2026 1945A Health Home Core Set.

Thanks, everyone, well done with pivoting to a new voting platform this year. We really appreciate all of the help from the team and also the Workgroup members in figuring out how to use this platform. Before we move into our break, I do just want to give a moment in case there

are any last comments from Workgroup members about this measure and the vote before we move on.

All right, well, we have come to the break in our agenda. So, we will resume the meeting at 12:30 p.m. Eastern. That gives you little less than a half-an-hour break. Please be prompt in rejoining, and we will kick off our discussion of the gaps in the Health Home Core Set. Thank you, everyone, and we will talk again soon.

BREAK

Patricia Rowan:

All right, hi, everyone. It is 12:30 p.m. on the East Coast. So, we will resume the second part of our meeting. I hope everyone had a nice break and is ready to discuss gaps in the Health Home Core Sets.

So, I think as most people know and was mentioned a lot during yesterday's introduction, each year the Workgroup discusses gaps on the Health Home Core Sets. The gaps conversation from each Workgroup discussion is intended to inform the Call for Measures for the subsequent Annual Review. This year, we are changing it up a little bit; and beginning with the 2027 Annual Review cycle, Mathematica will be conducting a Public Call for Measures. This is different in that previously only Workgroup members and federal liaisons were eligible to submit measures for -- suggest measures for consideration at these meetings. We will be moving to a Public Call for Measures where anyone can make those suggestions. So, to inform that, we would like to engage the Workgroup in a discussion of priority gap areas that could inform the 2027 Public Call for Measures. We will also be discussing the criteria for measure submission for the Public Call for Measures; and at the end of this conversation, we'll provide an opportunity for public comment. All right, on this slide is sort of how are we going to do that. Can we go back to the previous slide please? Thank you.

First, we would like all of the Workgroup to be thinking about the -- actually, maybe we *are* on slide 23. Can we move forward to slide 23? Thank you. Okay, sorry about that. So, we would like the Workgroup members to be thinking about the priority gap areas in the current Health Home Core Sets that could be addressed through a Public Call for Measures to both strengthen and improve the Core Sets. We know that over the years there have been lots of conversations and some questions about what measures are out there related to particular topics. We think that a Public Call for Measures will help to broaden the capture of potential measures that this Workgroup can consider.

So we also need to keep in mind the purposes and uses of the Core Sets, which are to estimate and understand the overall national quality of health care provided in Medicaid Health Home programs; to assess access to and care provided to health home enrollees; identify and improve understanding of disparities experienced by health home enrollees; and to use Core Set data to develop quality improvement efforts to advance health equity.

The approach that we are going to do for this gap discussion is to do a lightning round with Workgroup members. So, using the order of the roster for the roll call, which was organized alphabetically by last name, we will ask each Workgroup member to mention a priority gap area; or feel free to underscore or emphasize a gap area mentioned by another Workgroup member. We know that this may be challenging, but we want to make sure everyone's perspective is heard. Why don't we start that lightning round with our co-chairs Kim and Jeff to kick us off with

identifying what they see as one or two priority gap areas for the Health Home Core Set. Jeff, would you like to start?

Jeff Schiff:

Wow (laughing), sure, I think this will be fun to see where we go. I want to -- I'm looking at two, so I'm going to try to sneak them both in. The first thing I think is we really need measures of family and patient quality of life and well-being. I'll note that we don't have CAHPS as a consideration here, and we need some measure that will actually get to that outcome that we want most.

The second thing I'm going to squeeze in here is I think we need some measures around -- since this is not a state program, this is where we're measuring mostly how a state is doing; and as that slide with the different levels of measurement, this is more of program-level thing. I think we need to get into the measures of whether or not we have a good enough quality improvement infrastructure. I'll just give one quick example, which is that those federally qualified health care centers have 50 percent of their boards that are members of the community. The quality improvement infrastructure that involves families and beneficiaries in the program would be a good way to move quality improvement forward. I'll stop there, thanks.

Patricia Rowan:

Thanks, Jeff. Kim, do you want to go next?

Kim Elliott:

Hi, I have two areas that I think are gap areas for the Health Home Core Sets. The first is one of the foundations of the health home is the care coordination. So, measures relating to the use of and maybe the effectiveness of the care coordination components of health home I think would be a really valuable addition to the Core Sets. I think it's a pretty big gap that we currently have.

The second area is similar to what Jeff said related to patient experience or member experience. Some measure to determine satisfaction and members' experience on the effectiveness of the care coordination and service delivery in health home I think is also a gap area.

Patricia Rowan:

Thank you for that, Kim. All right, so now we will go alphabetically by last name. David, you would be up next. Go ahead.

David Basel:

Lucky me -- so, yes, first off, I think I'll revisit the last conversation a little bit, that I was one of those that voted against including the social needs metric this year. But I do think that that continues a gap and at the appropriate time needs to continue kind of in the hopper on things that we look at, and particularly maybe pacing it similar to other Medicare and Medicaid quality programs. And maybe starting with screening first before we move on to interventions might be a way to kind of pace that to help continue to keep it in the conversation and keep efforts moving forward without making them unrealistic or getting data that's so heterogenous that it's not worthwhile to analyze. So, I do think that's a continued gap even though I voted against it at this time with that particular proposed metric.

Then the other comment I'll also make is one that I've made multiple times, but I still think it's what I've always struggled with on this committee since we began it -- is trying to look at measures in isolation without looking at the overall suite of measures and how we can tie adding a measure to removing a measure or how do we prioritize measures as we go through this process. It's been very hard for me to look at one in isolation without knowing how it fits in the bigger picture sometimes. So, appreciate that opportunity.

Patricia Rowan:

Thank you, David. Macy Daly? Do we have Macy? Go ahead. Macy, are you still muted? Why don't we come back to Macy. I'm not hearing Macy. Ari Houser? Is Ari here?

Ari Houser:

I am here. I'm going to -- similarly to David, I'm going to identify a gap of a measure that we voted down during this meeting. That to me is the biggest gap or the most apparent gap that I see is measures of diabetes screening and management just with the sheer burden of that disease. Something like half of adults have diabetes or pre-diabetes in the United States. I realize we didn't select or didn't recommend the selected measures this time around, but it still seems to be a large gap in the measure set.

Patricia Rowan:

Thanks for that, Ari. Amy Houtrow? Do we have Amy?

Amy Houtrow:

Amy Houtrow -- you know, I really appreciate what people are saying about process and how we think about evaluating the measures. I think that's worthy of the Mathematica group to take back. In regards to that, I think there could be a strategy where we look at those overarching Venn diagram categories and talk more explicitly through them as we get ready to vote.

But what I would like to bring up is -- where I feel like there's gaps is that there's lot of programs out there; and although there might be a framework or what they hope to achieve, it doesn't feel like we're always rowing in the same direction or prioritizing in similar ways. A few years ago, I worked with the Maternal and Child Health Bureau for the blueprint for change for children with special health care needs. It seems like we could be doing some alignment that focuses on the same sorts of strategies that other kind of federal organizations that are tasked with the work of keeping people healthy share and that that could help guide us in understanding our gaps and then attempting to fill those gaps.

Patricia Rowan:

Thanks, Amy. Pamela Lester? Do we have Pam?

Pamela Lester:

Yes, hi, I think the QI focus was a great addition to the gaps because if we have that, it makes all this other work easier to use a data-driven approach to improving outcomes for members. I also did struggle with the diabetes metric for the same exact reason -- because it is a high-cost and poor outcomes for our members and how do we close that gap that’s been a gap for a couple of years for us.

I think part of the issue from that, which is my one priority gap area, is there's such a difference in populations within the different health homes. While we're supposed to provide whole person care, it seems to be a struggle to focus on behavioral health type of measures for those with behavioral health homes because that doesn't align with maybe some of the other focuses for health homes. So, for me, it's just kind of a struggle of how do you figure that out? Because there are just a high number of people within health homes whether the focus is visible health, complex needs, or behavioral health to focus on that area. So how do we allow for measuring to show improvement in the different types of populations of focus for the health home programs?

Patricia Rowan:

Thanks so much, Pam. Libby Nichols? I'm not sure if Libby is here or connected to audio. If not, why don't we move on to Kayla Romero. Kayla, are you here? Go ahead. Kayla, we are not hearing you. Not sure if you're muted locally - - your phone or headset. There we go. Now we can hear you.

Kayla Romero:

I'm so sorry. So, with my statement, I would have to go with the diabetes as you mentioned prior just because there are a variety of different populations that the health homes are (inaudible) kind of encountered with and I think that there should be a focus on solving or working on that gap just to ensure that health homes are successful in working on that measure. And then I think somebody did mention that there are so many programs that it just does not seem like we are working in the same direction and we should just align on focusing on the same strategies just to guide us in understanding specific gaps and just so that we all can be on the same page and focus on the same measures that we are all kind of closing on the same goal in. Thank you.

Patricia Rowan:

Thanks, Kayla. Your audio was a little rocky, but I think I heard. You said diabetes measures and also the need to align with other quality measurement programs and initiatives. If I got that wrong, feel free to raise your hand and unmute. Okay, I think next up we have Pamela Tew. Do we have Pamela?

Pamela Tew:

Yes, can you hear me?

Patricia Rowan:

We can, yeah.

Pamela Tew:

So, I really appreciated the discussion today around the screening for health-related social needs measure. I think connections to services are so critically important, and it's clear we're not there yet. But I think in terms of driving quality of whole person care for young children especially where those early years are so critical in terms of development and social/emotional development, that's a critical gap area to figure out how to fill.

Patricia Rowan:

Thanks, Pamela. Sara Toomey? Do we still have Sara? Go ahead, Sara.

Sara Toomey:

Can you hear me?

Patricia Rowan:

Yes, we can.

Sara Toomey:

Great, perfect, I'm just going to be brief because I want to reiterate some of the things I heard that I think are really important. So, a combination of a couple of comments around making sure that we're looking at the slate as a whole -- not only, as I think David had said, to make sure it's a parsimonious slate, but then it also fits together in terms of the measures in particular as we think about sort of where those gaps are.

And then to Amy's point, also the alignment across different programs I think is really important. Being part of a system that has many different requirements for different programs that we participate in, the more alignment that can be driven across them, the greater likelihood there is that we're able to make meaningful, impactful change. So, I think that is a very important comment.

In terms of the measures themselves, I agree with both the patient experience quality-of-life measures and in addition care coordination, given the focus of the health home program overall. Then I do think that there is a role in particular, given what this program is doing around health-related social needs. I think that we just need to make sure it's being done in time for where it can be thoughtfully implemented and uniformly --- that the programs are given the resources they need to make those meaningful connections provide what their patients and members will require. Thank you.

Patricia Rowan:

Great, thank you. Laura Vegas? Do we have Laura? Go ahead, Laura.

Laura Vegas:

Hello, in agreement with what most of the group has already said, I agree that there are some gaps in terms of measures around the care coordination and the case management component of the health home. To me, they're kind of like the heart of the health home. So, if those pieces aren't working, it's hard for me to see the benefit of this program for people with chronic health conditions.

I also think about social isolation and people being connected to their communities. I'm from an LTSS background, and that's really something we pay a lot of attention to. While the health conditions absolutely have to be managed and supported, that's just part of what makes a quality of life -- back to the quality-of-life conversation. So would like to see some more of a balance of looking at measures around acute health care versus quality-of-life satisfaction.

Patricia Rowan:

Thanks for that comment, Laura. Jeannie? Do we have Jeannie?

Jeannie Wigglesworth:

Hi there. So, in one of the recent focus groups that I did in Connecticut, one of the -- and looking at our population health for our health home populations, interestingly enough sepsis is a *huge* issue for the SMI population for going in for medical reasons -- for inpatient and ED, overwhelmingly so. So that would be an interesting topic for us to look into, as well as the barriers around getting dental care was also an issue. Again, I can only really speak to the gaps and barriers of the population that I know, which kind of brings me to the next point.

I think what I would find beneficial is if I could work with other behavioral health homes that also work with similar populations. I could then probably generalize more nationally towards gaps. I mean, it's kind of hard enough even trying to figure out Connecticut because it has so many different working parts and systems. But figuring out gaps *nationally* is quite difficult for me to conceptualize, specifically because I'm just working with this particular one population and another health home is working with a totally different population. I mean, I know we're all coordinating care; however, each state works differently and is working on a different populations. That's why some measures may work for some people and may not for others.

It would be great if we could have the states that work with similar populations kind of work together. We could maybe -- maybe instead of adding measures to everybody, maybe there's certain measures certain groups do, and certain measures certain *other* groups do, where they can become the subject matter experts more in certain areas -- I don't know. That's all I have. Coordinating care is always important, and it is the crux of everything. It's just so hard to measure. I don't know how you would measure it, but it is another important piece and important one. So, I agree with many who talked about the coordination of care.

Patricia Rowan:

Okay, thanks, Jeannie. Let me see...do we have either Macy Daly or Libby Nichols connected to audio now? Libbie, go ahead.

Elizabeth Nichols:

Hi, I feel like really I'm in some ways -- I don't know that I have anything unique to add. I really what to echo what people I think have said very eloquently. Sara Toomey really said *exactly* what I would have said.

The things that I think are high level to me are I think there's a clear need for something around sort of social determinants -- social care needs. I also think that the reality is, thinking of what Jeannie just said too, the reality is the things that kind of unite most of the health home programs are really that care coordination piece more than they are the populations. It would be helpful to understand or have a little bit better mapping of which populations are where and who's programs are similar and who are different. There might be opportunities for collaboration and conversation there.

But in the absence of really being able to necessarily pinpoint every single population -- and then you're going to have measures on a population -- is it covered elsewhere? I think that

looking for those social care needs and care coordination would be fantastic. It's just also sometimes tough to get the timing of when a measure is really ready to be implemented.

And I think it's really important to consider that -- echoing David's comments -- like considering that we want it to be a parsimonious list, and we want it to be really targeted to measuring impactful things so that we don't kind of end up in an endeavor -- if everything's important, then nothing is important situation. So really, I'm just echoing what everyone else has said.

Patricia Rowan:

Thanks for that, Libby. Do we have Macy Daly? I don't know, Macy, if you're able to come off of mute.

Macy Daly:

I'm not sure--

Patricia Rowan:

We can hear you now, go ahead.

Macy Daly:

Okay, sorry, I think I was locally muted, and I didn't realize. I apologize. I also enjoyed the discussion. I don't think I have too much to add. But I agree that if there's some way to sort of work into this process in some form -- like being able to holistically look at the measures. I know we were sort of saying during a lot of the discussion, a lot of these measures have merits or evidence based; and they would be beneficial. But it's harder to think about is this the most beneficiary? Are we capturing -- is it giving us enough utility to consider adding it? So again, I think having all of the measures together -- but, yeah, I agree. Obviously, housing and employment and other social determinants of health are so important to helping folks live a healthy life. So, if there's a way for us to incorporate that, I think that would be good. Thanks.

Patricia Rowan:

Thanks for that, Macy. I also want to give an opportunity for our federal liaisons to weigh in on this. So, if we have any federal liaisons on the phone from AHRQ or CCSQ or HRSA or any of the other federal agencies here that would like to share their thoughts on gaps in the Health Home Core Sets, now is a good time. I see Peggy. Can we unmute Peggy?

Go ahead -- and, Peggy, if you don't mind, just introduce yourself and remind everyone which organization you're with. Peggy, we're not hearing you. I'm not sure if you're muted locally. Are you there, Peggy?

Are there other federal liaisons who would like to make a comment while we wait for Peggy?

Peggy, not sure if you're muted on your phone or your headset.

Derek, is there anything we can do to unmute Peggy?

All right, Peggy, want to try again?

Derek:

Tricia, this is Derek. So, Peggy's line might be muted locally. Peggy, I would suggest just checking your audio settings just to make sure that you're connected through your computer audio.

Patricia Rowan:

Peggy, I do see your comments in the Q&A. If you can't get yourself off mute, if you want to put a statement in there, I'm happy to read it out loud; or you can email it to us as well. Other federal liaisons who would like to make comments on gap areas?

All right, what about any other Workgroup members who would like to highlight any gap areas that either you thought of while the conversation was going on or weren't mentioned? Just before we move on, I'm happy to give another minute here. Jeff, go ahead.

Jeff Schiff:

I am sorry we can't hear from Peggy, but hopefully soon. I just wanted to point out something that -- and this may be more for our federal liaisons to hear. But health home is -- we're here to talk about one specific program to address the needs of folks with medical complexities: but in the federal HHS, there's a lot of programs. This is a recommendation maybe not for the health home set but maybe for the Core Set , but we could, if --what would be the outcome if we stratified the Adult and Child Core Set by both race/ethnicity and language but also by disability or some level of medical complexity, where we might learn more about access and quality for the population as a whole since a small part of the population that has these complex needs is actually served by this population?

So, I wanted to bring that up, and then the other thing I just wanted to mention is that related to the parsimony of the set, I think that -- and I think people are pretty aware of this -- but I think that frontline providers see many of the measures that come out nationally as can be a burden. We've done a lot with electronic data reporting, et cetera, to make that less so. But I think that if there's a way to make the -- to think more about how to like with the quality improvement sort of things, how to make frontline providers more invested in some of the programs and pay attention to their needs both in terms of the burden of reporting but also I'll add two other things -- in terms of their ability to get access for their patients and then also their compensation for doing the kind of work that we really want them to do. That would be really helpful. Thanks.

Patricia Rowan:

Thank you, Jeff. One thing I will mention is that disability status is one of the stratification components for Core Set reporting both Child/Adult and Health Home -- just not yet. CMS is still exploring options for how that is defined, and more guidance will be forthcoming on that. So, I just wanted -- that is one piece of your comment I wanted to respond to.

Jeff Schiff:

Oh, great, thank you.

Patricia Rowan:

And then Peggy was able to send in her comment, so let me read it aloud. This is from Peggy O'Brian. She says, "I think a better understanding of the spread and diversity of the health home and thinking about it globally is important. With regard to diabetes measures, there are broader diabetes measures that would address the entire population without narrowing to a behavioral health-specific denominator." Thank you for that, Peggy. All right, why don't we move on to the next slide?

So now I would like to pivot a little bit to discuss the criteria for measure suggestions that will be used for the Public Call for Measures. We've provided a few questions here on the slide to guide our conversation; namely, when you think about the criteria we have this year -- the Call for Measures criteria for 2026, which we talked about yesterday, but we'll revisit here -- what changes would *you* suggest for the 2027 Public Call for Measures?

For example, are there criteria under the areas of minimal technical feasibility, actionability, and strategic priority or other considerations that you think are missing or criteria that you think are no longer serving the purpose and the goals of the Core Sets? And are there other criteria that you would suggest as we move into the Public Call for Measures?

So please keep these discussion questions in mind as we go to the next slide. So this slide shows the criteria for suggesting measures that we used this year. So, these are the criteria for suggesting measures for addition to the 2026 Health Home Core Sets. We'll just kind of keep this slide up for your reference during our discussion, but we would like to invite comment from the Workgroup on these criteria. So again, if you think that there are criteria here that are no longer serving their purpose or criteria that you would add, we want to hear from you as we refine this annual review process.

So please use the Raise Hand feature like we've been doing all day, and I'm looking forward to this discussion. So let me open it up now. Kim, go ahead.

Kim Elliott:

Overall, I think that the criteria is really effective and particularly when Mathematica team members do such a great job of making sure that the measures are submitted for consideration, be recommended as measures, meet all of the criteria. I think some of the other considerations are probably really a key at this point in determining what makes the most sense for measures, particularly like the prevalence of the condition or outcome being measured because the health home really does have specific criteria for each of the unique health home programs in each of the states.

So, I think overall I'm really satisfied with the criteria that's included.

Patricia Rowan:

Thank you, Kim. Jeff?

Jeff Schiff:

Hi, I agree overall. I have a refinement that I might want to say; and that's when we look at actionability and strategic priority, we think about who the actionably entity mostly is. Because I think in this program, as I said earlier, the actionable entity is really a program, or a provider

organization as opposed to what we think about for the Adult and Child Core Sets. It might be worthwhile to ask folks who the actionable -- who they see as the most actionable entity as they submit measures in a public call.

Patricia Rowan:

That's a really helpful point. Other comments on the criteria? For those of you who have submitted measure suggestions for addition, were there any criteria that were particularly difficult for you to demonstrate in the forms or where you thought we could provide more information that we should consider for when this goes public?

And I know we kind of sprung this discussion on you; so, if you think of something afterwards, you all know where to find us. We'll share the team's email address again as we wrap up. But, yeah, we're actively thinking about how to refine this process for a Public Call for Measures and, yes, are really interested in your feedback.

Maybe one thing that I would just probe a little bit on is one of the themes that came up quite a bit in the gaps discussion was how helpful programs can serve different populations, right? Some are focused on behavioral health; some are mental illness conditions. Are there any suggestions for the criteria that might address that concern, or is that more of a suggestion for technical assistance or perhaps like learning collaborations for states that are serving similar populations through their health home programs?

Oh, that must have sparked some interest. Jeannie, I saw your hand go up first. Do you want to go ahead?

Jeannie Wigglesworth:

Yeah, I'm not quite sure that would -- from my opinion, I'm not sure that would be any changes for the public comments. That, to me, was more towards more education and learning opportunities so that we can make better -- I guess, better suggestions for measures in the future having more information under our belts. Do you know what I mean?

Patricia Rowan:

Yeah. Kim, I saw you also wanted to add something here. Go ahead.

Kim Elliott:

Yeah, I agree with what Jeannie said. I don't know that necessarily changes the criteria. I think balance is *really* important in the core measure sets. Sometimes it's a product of what measures are available that address the types of members that are included in the different programs across Medicaid. But there sometimes is a little bit of imbalance. We have a lot of measures focused on one specific area -- maybe it's chronic illness, maybe it's behavioral health -- so a little bit more balance that addresses the whole person.

I know that's probably more of -- it's not really a gap discussion, but just how we balance out those measures as we think about recommendations. It's just something that always preys on my mind. I really want to consider things that really represent that whole person because we need that full person in every aspect related to the care and service delivery to be recognized, to have overall quality of health/quality of life for those individuals.

Patricia Rowan:

Thanks for that, Kim. Jeff?

Jeff Schiff:

I agree with Kim. I just wanted to say that one of the things for Public Call for Measures may be giving some feedback on what the programs contain and what populations they're dealing with. I know the programs I've been involved in, but I don't know all of them. So, if they're all behavioral health/physical health integration, then the Call for Measures may be more likely to focus on that if we have some measures that are on, say, pediatrics complex medical conditions will have different things that will be relevant. So maybe it would help to give a little more information to folks as we go forward. Thanks.

Patricia Rowan:

Yeah, that's a really helpful suggestion, Jeff, because we're also thinking about what sorts of resources our team makes available to support people in making those measure suggestions. In the past, we've been able to report out on things like what percentage of health home programs are serving different populations, and then how does that translate to the number of enrollees. I think having a little bit more of that demographic information of who is served by Medicaid Health Home programs can inform these discussions well. Other comments on the criteria?

All right, well, we mostly focused our conversation today on those criteria for addition. As you know, the criteria for removal are kind of just the opposite side of the coin; so, we won't discuss those separately but really appreciate folks' insights and suggestions here. Why don't I move on to the next slide?

At this point, we would like to provide an opportunity for public comment on either gap areas in the Health Home Core Sets, as well as the criteria for the Public Call for Measures. So, if there's anyone on the phone who would like to make a comment about either of these discussion areas, please use the Raise Hand feature in the bottom-right section of the Participant Panel; and we will unmute your line.

All right, I am not seeing any public comments. So why don't we move on to the next slide? Okay, so we have covered a lot of ground today and yesterday. As we prepare to wrap up, we would like to -- as we usually do -- provide an opportunity for reflections.

Let's go to the next slide. This slide recaps the agenda for this part of the meeting. So let me start by just recapping where we were. So, the Workgroup considered a total of three measures for addition to the 2026 Health Home Core Sets. As a reminder, to be recommended for addition we needed at least two-thirds of the Workgroup to vote in favor of addition. Thanks to everyone for navigating the voting technology. Of those three measures that were suggested for addition, the Workgroup did not recommend any measures for addition. We considered measures of Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications and also Metabolic Monitoring for Children and Adults on Antipsychotics. Both of those measures only received 54 percent of the Workgroup voting in favor. Then today, we talked about the Social Needs Screening and Intervention, and only about 15 percent of the Workgroup voted in favor of adding that measure.

Even given those voting results, we did hear a lot during the gaps conversation about the importance of measures of diabetes, particularly for the population that is being served by

health home programs. Also heard a lot about the needs to address social needs and social determinants of health; but some pause and concerns from the Workgroup around the particular measure that was under consideration and whether there would be significant feasibility challenges for states to report that.

We also heard a lot about alignment across quality measure initiatives. The quality measure landscape for Medicaid programs is evolving a lot. We got final rules this year for mandatory reporting. There was a final rule recently for Medicaid access that will impact reporting for HCBS programs, and there's a lot out there. We heard a lot from Workgroup members about the need to align those efforts where possible. I think Sara's comment about when multiple funders or multiple quality programs are looking at similar things, it increases the chances of moving the needle in a significant way was a really good way of summing up that concern.

All right, so we also would like to hear Workgroup member suggestions for any technical assistance needs that might help states with reporting Health Home Core Sets measures. We did hear a little bit about this during the gap discussion on maybe connecting states that have health home programs serving similar populations. But let me just pause here and see if any Workgroup members have comments or suggestions on additional technical assistance resources that either the Mathematica team or the CMS Team could provide for state reporting.

Pamela, go ahead.

Pamela Lester:

Hi, I think that having -- for example, when I was researching the measure Metabolic Monitoring for Children and Adolescents on Antipsychotics, AHRQ has a great toolkit to use for all levels to identify areas of improvement for that measure to make it more usable and easier to make those improvements on those measures. I think having that resource for the measures so it's not specific to reporting measures, but more specific maybe to digesting and using the measure for quality improvement.

Patricia Rowan:

That's really helpful. Thank you, Pamela. Any other comments on technical assistance needs?

All right, we also like to provide an opportunity at the end of these meetings in the spirit of quality improvement to ask Workgroup members for opportunities for the Mathematica team to improve the review process next year. As I mentioned, we'll be doing a Public Call for Measures. This is also the fourth year of the review, which means that some of our Workgroup members who have been in part of the group for a while will be rolling off; and we will be looking for some additional representation from states on the Workgroup. So, any thoughts or comments on ways you would like to see the review process changed or improved? Go ahead, Amy.

Amy Houtrow:

Hi, this is Amy Houtrow; and I am one of the folks that is rotating off. I have long felt that the structure of these meetings doesn't allow us to function really as a workgroup, which I think is unfortunate because there's so much wisdom in the individual folks. I think our dialogue would be richer if we weren't held so tightly to no video and no control of our own audio.

We noticed today that it was very hard, as it was yesterday, for audio management to occur. It's hard to know what's actually going on when you can't engage with people, can't get to know them, don't really have an opportunity to feel like colleagues. I think we could really do better by this process, which might end up taking a longer time but result in a much richer discussion, make people feel more confident in the dialog and the resulting conclusions. Because for me personally, one of the things that I enjoy about this type of work is really learning from the wisdom of folks who are doing the work, who are measuring the work, thinking about the work, planning the work. I don't feel like this structure really allows us to do that adequately.

So I would strongly encourage a rethinking of this very tightly controlled WebEx webinar style to move to something more like we did pre-pandemic, where we were all in the same room together for these type of meetings; and we were getting to know each other, having dialog, being able to see the smiles on other people's faces, and the quizzical looks that people give because I think that's really a very important part of how we interact professionally as colleagues, which has been taken away from us in this. It makes me concerned that because of the way it's structured, we're missing important opportunities for collegiality and dialog and learning from others.

I know this is something that I have brought up before, but I just feel it's worth mentioning again because I would really have liked over these last years to have gotten to know the people that I was dialoging in a way that is not possible when you won't allow us to really engage in any of that dialog except in a very controlled manner.

Patricia Rowan:

Thanks, Amy. I know we're constantly trying to balance the need to have a fully public and transparent process with the need to help create connection here, so we always appreciate your feedback. Are there other comments about the process? Amy, did you want to add something? Go ahead.

Amy Houtrow:

I did. The point about it being a public process, which again I think it's exceptionally important that it is. We talked about the use of the telephone or not using video because of people's access to the Internet. But that brings up issues around accessibility generally, and I'm wondering if it's something that Mathematica could consider doing -- is having disability-related accommodations available, such as live captioning or sign language interpretation that may be making the meeting more accessible to those with disabilities.

Patricia Rowan:

Thank you for that suggestion, Amy. Other comments on this topic before we move on?

All right, I'm going to go to the next slide. I think we just have one last opportunity for public comment or other comments on any of the topics that have been addressed today before we close.

Okay, I'm not seeing any hands raised; and I'm sure we could all use a little bit of time back in our afternoon. So why don't we just move on to the next slide? I would like to thank everyone again for your participation, your flexibility, and your patience in conducting this meeting and would like to give our Co-Chairs a final opportunity to make any remarks. Kim, would you like to go first this time?

Kim Elliott:

Sure, I'm happy to. I would like to thank everyone for all of the time and dedication that is put into preparing and of course participating for this meeting. Particularly at Mathematica, you just do an incredible job getting everything ready and all of the information available, all the resources you provide to us so that we can do our jobs very efficiently. I'd like to thank CMS, the federal partners, the measure developers, really all of the Workgroup members for a very, very helpful and productive Health Home Core Set review meeting this time.

The measures we discussed during the meeting were focused on addressing the prior meeting's gap discussions, including the screening for diabetes and addressing social needs. There seem to be recurring themes often when we have the gap discussion. As evident from our voting on the measure recommendations, sometimes no change in the measure recommendations is appropriate based on all of the subject matter expertise that's brought to the discussion.

The discussion on gaps and opportunities was also very thoughtful and informative; and Workgroup members really demonstrated that it is truly a balance to consider what may fill the gaps and also be aligned, desired, feasible, viable to consider for inclusion in the Core Sets. So that discussion is really an amazing part of this process, and everybody had such good input into that part of the meeting.

So, thank you for your engagement throughout the meeting, the passion everyone demonstrated for the health home program itself and those served by the health home program. It really makes a huge difference throughout our discussion and where we're heading with the Core Measure Set for Health Homes. Jeff?

Jeff Schiff:

Great, Kim, thank you very much. I agree with what you said. I just want to add that it's an honor to be part of this process. I think that the group that's assembled here is amazing in its dedication to the service of the community, and I thank everybody for being here.

I want to say that as we go forward and look at the gaps, it would be lovely to go back and look at gaps over time. I'm getting old, but I'm not old yet; and I want to be a little impatient about how we get to resolve some of these issues. So, I look forward to the Public Call for Measures. I look forward to working with hopefully many of you again in the future here or in other places. I just want to thank Mathematica and then the Committee for its service. Thanks.

Patricia Rowan:

Great, thanks, Kim and Jeff. We appreciate your support and leadership in this review. Next slide. So this slide probably looks familiar, but it lays out the key milestones for the 2026 Health Home Annual Review process. Our journey began back in January and continued with a June 5th webinar a couple weeks ago to get organized for our voting meeting this week. We are so grateful for the time you've taken to prepare for this meeting and that you spent the better part of two days with us.

Our next step at Mathematica is to review and synthesize the discussion that has occurred over the last two days and prepare a Draft Report. That Draft Report will be make available for public comment in August. In addition, Workgroup members will have an opportunity to review and comment on the report. The Final Report will be released in October after we receive all from the public comments. From there, CMS obtains additional input from interested parties,

including other federal agencies and state Medicaid leaders to make their final decisions on the Health Home Core Sets, which they will release by December 31st.

Next slide. If anyone has any questions for our team about the content of this meeting or the annual review process, our email address is shown here on the slide. It is MHHCoreSetReview@mathematica-mpr.com. So that's M-H-H, as in Medicaid Health Home Core Set Review. Feel free to reach out to us. If you think of other feedback on the Public Call for Measures or gaps, we are always open to that input. Finally, one last thank you to all of our Workgroup measures, federal liaisons, measure stewards, and members of the public for your contributions. Thank you also to Sara Rhoades and Lauren (inaudible) others in the Medicaid Benefits and Health Programs Group at CMCS. A huge shout-out to my team here at Mathematica for all the work that they have done to get us through this review process. None of this would be possible without that help.

Next slide. So thank you again for your participation. We wish you well. This concludes the 2026 Health Home Core Set Annual Review Workgroup meeting. Our meeting is now adjourned. Thanks, everyone.