Mathematica 2026 Health Home Core Sets Annual Review: Orientation Meeting Transcript January 31, 2024, 1:00–2:00 p.m. EST

Madelaine Spiering:

Welcome, everyone, to the 2026 Medicaid Health Home Core Sets Annual Review Orientation Meeting. My name is Madelaine Spiering, I am a Health Analyst at Mathematica. Before we get started, we want to cover a few technical instructions. 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 have any issues speaking during Workgroup or public comment, please make sure that you are not also muted on your headset or phone. Connecting to audio using computer audio or the "Call Me" function in WebEx are the most reliable options. Please note that call-in-only users cannot make comments. If you wish to make any comments, please make sure that your audio is associated with your name in the WebEx platform. 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. You will hear a tone when you have been unmuted. Please wait for your cue to speak and remember to mute your line when you are done speaking. Also, please lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the Chat is disabled for this webinar, 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 "Control+Shift+A" on your keyboard to enable closed captioning.With that, I will turn it over to Tricia Rowan. Tricia, you have the floor.

Patricia Rowan:

All right, thanks, Maddy. Good afternoon, everyone, or good morning if you're joining us from a different time zone. I am Tricia Rowan, a Principal Researcher at Mathematica. My colleagues and I are part of Mathematica's Technical Assistance and Analytic Support Team for the Medicaid and CHIP Quality Measurement and Improvement Program, which is sponsored by the Center for Medicaid and CHIP Services. Welcome to the orientation meeting for the 2026 Annual Review of the Medicaid Health Home Core Sets. Whether you're joining us live or listening to a recording, thank you so much for being here. I hope you're all doing well and ready to start this journey again together. Next slide.

I'd like to quickly share with you the objectives for our meeting today. First, we'll introduce our Workgroup members. We're so excited to welcome returning Workgroup members, as well as several new members joining the Workgroup for the first time. This year's review will focus on updates to the 2026 Health Home Core Sets for both the 1945 and 1945A Health Home programs. Next, we'll describe the charge, timeline, and vision for the 2026 Annual Review. Finally, we'll present the process that Workgroup members will use to suggest measures for removal from or addition to the 2026 Health Home Core Sets. Near the end of our meeting, we'll provide an opportunity for public comment. So if you'd like to make a public comment, you should be able to unmute yourself at that time and share. As you can tell, we have a full agenda today. The purpose of this meeting is to convey information about the review process. We won't

have much time today to engage in discussion about the Core Set or any individual measures, but there will be plenty of time for that at our June voting meeting. Next slide.

I'd like to take a quick moment and acknowledge my colleagues at Mathematica who are part of our Health Home Core Sets Review Team. Margo Rosenbach is our Project Director, and you've heard from both Maria Dobinick and Maddy Spiering today. Next slide.

Now I'd like to take this opportunity to introduce the Workgroup for the 2026 Health Home Core Sets Annual Review. In the interest of time today, we won't do a formal roll call. So, this slide and the next slide list the Workgroup members, their affiliations, and whether they were nominated by an organization. However, as we've mentioned in the past, Workgroup members who are nominated by an organization do not represent that organization during the review process. All Workgroup members are here to provide their expertise as individuals and not as representatives of an organization. I'd also like to welcome back the continuing members of our Workgroup, and to thank Kim Elliott and Jeff Schiff for agreeing to serve as our Co-chairs again this year. We so excited to welcome several new Workgroup members who are indicated on this slide with an asterisk or star after their name. Next slide.

This slide continues with the Workgroup roster. And again, new members are denoted by that asterisk after their name. As you can see from these two slides, we have assembled a diverse Workgroup that spans a range of perspectives, quality measure expertise, and Health Home Program expertise. Thank you to everyone, all of our Workgroup members, for your service. Next slide.

This slide shows a list of federal liaisons, which reflect CMS's partnership and collaboration with other agencies to assure alignment across federal agencies and programs. Federal liaisons are non-voting members of the Workgroup, and we thank them for their participation in this annual review process as well. Next slide.

Disclosure of interest by Workgroup members is designed to ensure the highest integrity and public confidence in the activities, advice, and recommendations of the Annual Review Workgroup. All Workgroup members are required to disclose any interests that could give rise to a potential conflict or appearance of a conflict related to their consideration of quality measures for the Health Home Core Sets. Each member will review and update their Disclosure of Interest form prior to the voting meeting in June. Any members deemed to have an interest in a measure that is submitted for consideration will be recused from voting on that measure. Next slide.

Now I'll take a moment to review the Workgroup charge. The 2026 Health Home Core Sets Annual Review Workgroup is charged with assessing the existing Health Home Core Sets and recommending measures for addition or removal in order to strengthen and improve the 1945 and 1945A Health Home Core Sets. The Workgroup should focus on recommending measures that are actionable, aligned, and appropriate for program-level reporting to ensure that measures can meaningfully drive improvement in health care delivery and outcomes for Medicaid Health Home Program enrollees.

With mandatory reporting requirements beginning in 2024, the Workgroup should closely consider the feasibility of State reporting by States for all Medicaid populations that are enrolled in their Health Home programs, as well as opportunities for advancing health equity through stratification of Health Home Core Set measures. With mandatory reporting on the horizon, we appreciate the participation of our Workgroup members from States and encourage them to

share their experiences and insights with quality measurement and improvement using the Core Sets and other measures. Next slide.

This slide is a visual representation of the milestones for the 2026 Annual Review process. Thank you for joining us for today's orientation meeting. Tomorrow, Workgroup members will receive the Call for Measures for the 2026 Annual Review. February 29th is the deadline for Workgroup members and federal liaisons to suggest measures for removal or addition. On June 5th, we will reconvene the Workgroup to prepare for the voting meeting. At that time, we'll introduce the measures that were suggested for consideration during the 2026 review and describe the process that we will use to discuss and vote on measures. The voting meeting will be virtual and take place across two days, June 25th and 26th. Note that all of these meetings are open to the public. This process will culminate in the development of a report that's based on the recommendations of the Workgroup. That draft report will be made available for public comment in August; and the final report, along with additional input, will inform CMS's updates to the 2026 Health Home Core Sets. Next slide.

Now we want to discuss the vision for this year's annual review. I'll start with some big-picture thoughts and then move on to some more detail. Next slide.

First, we want to share some thoughts with the Workgroup about their role in strengthening the 2026 Health Home Core Sets building on our experiences over the last few years. As you know, this annual review process is designed to help identify gaps in the existing Health Home Core Sets and suggest updates to strengthen and improve them.

As we have highlighted in previous years, there's an inherent balance across three facets of desirability, feasibility, and viability that you can see here in a Venn diagram that depicts that intersection of the desirability of measures from diverse perspectives, technical feasibility for program level of reporting, and financial and operational viability given State resources. While there are many good quality measures, 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. Next slide.

This graphic is a representation of the concepts of multilevel alignment of quality measures. At the bottom, we have measures at the clinician or practice levels, which feed into measures of 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. At the next level up, the Child and Adult Core Set measures are considered State-level measures because they are intended to capture all Medicaid and CHIP beneficiaries within the State. State-level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP Program as a whole. CMS values alignment of quality measures across programs and levels because it can help drive quality improvement by addressing each unique level of care so that improvement at one level can lead to improvement at other levels. Alignment is also intended to streamline data collection and reduce reporting burdens. Next slide.

Beginning in 2024, reporting of the Health Home Core Set measures will be required for all States that have approved Health Home programs that have been in operation for at least six months of the reporting period. So we ask the Workgroup members to consider feasibility and viability of both current and future Health Home Core Set measures as mandatory reporting begins.

We also ask the Workgroup to consider whether a measure could be stratified by such factors as race, ethnicity, sex, age, rural or urban status, disability, and language. We encourage Workgroup members to carefully review the criteria for the Call for Measures to assure that suggested measures balance those considerations related to desirability, feasibility, and viability in the context of mandatory reporting. Recommendations should also consider whether all Health Home programs can report a measure within two years of the measure being added to the Core Sets for all populations that are enrolled in the Health Home program.

Also, as you think about whether a measure is a good fit for the Health Home Core Sets, we encourage you to consider how the measure advances access, quality, and equity. Ultimately, the goal is for States and their partners to use Core Set data to identify disparities in Health Home program care delivery and outcomes to develop targeted quality improvement efforts that advance health equity. Next slide.

We want to take a moment to acknowledge that there are good and important quality measures that may not meet the criteria for inclusion in the Health Home Core Sets. We encourage Workgroup members and federal liaisons to recognize that there are *many* other venues to use measures to monitor quality and drive improvement at the national, State, health plan program, or provider level. Other tools include the Medicaid and CHIP scorecard, the beneficiary profile, the managed care quality tools, Section 1115 demonstrations, State plan amendments and waivers, State-directed payment programs, and pay-for-performance and value-based purchasing initiatives. So measures that may not be a good fit for the Health Home Core Sets could be appropriate for use in some of these other venues. Next slide.

Now I'd like to invite Sara Rhoades to share CMCS's vision for the 2026 Health Home Core Sets Review. Sara, you have the floor. You should be able to unmute.

Sara Rhoades:

Hi, everyone, welcome. I'm Sara Rhoades, the Technical Director for Health Homes.

Overall, everything that was just mentioned -- we want to make sure that we're looking at measures that can actually be reported by States, given that we're moving into our mandatory reporting for 2024, as well as the other focal point is being able to stratify and looking for any measures that may bridge any gaps or disparities. So welcome and thank you all for joining.

Patricia Rowan:

Great, thanks, Sara. Next slide.

Now I'm going to turn it over to Maria Dobinick, who will present a brief overview on Medicaid Health Home programs that will help Workgroup members prepare for the Call for Measures. Maria.

Maria Dobinick:

Thank you, Tricia. Next slide.

To help frame the review of the Health Home Core Sets, we'd like to provide some background information on the 1945 and 1945A Health Home programs. After the meeting, we will provide

workgroup members with additional information and resources about the Health Home Core Sets to support your suggestions for adding or removing measures.

I'll start by providing information about Section 1945 Health Home programs, and then Sara Rhoades will discuss the 1945A Health Home Program option. 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 AIDS or HIV, may be considered by CMS for approval. Next slide.

This slide lists the six core services provided by Health Home programs. They include comprehensive care management; care coordination; health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support services; referral to community and social services; use of health information technology to link services as feasible and appropriate. Next slide.

This chart shows the distribution of Health Home programs by target population over the last three reporting cycles. In FFY 2023, the most recent reporting cycle, there were 14 Health Home programs serving individuals with serious mental illness; 8 programs serving individuals with chronic conditions; and 5 programs serving individuals with substance use disorders. There are also five hybrid Health Home programs, which refer to those that have two or more focus areas. And there is one Health Home program focused on supporting individuals with HIV or AIDS. Next slide.

Now turning to quality reporting for 1945 Health Homes. CMS established the Health Home Core Set of Quality Measures in January of 2013 for the purpose of ongoing monitoring and evaluation across all Health Home programs. States reported Health Home Core Set measures for the first time in FFY2013, and States recently finished reporting for FFY 2023. As a condition of payment, Health Home providers are required to report quality measures to the State, and States are expected to report program-level measures to CMS. As mentioned earlier, States are expected to report all of the1945 Health Home Core Set measures, regardless of their focus area. Next slide.

This slide contains information on the number of Health Home programs reporting on the 11 Health Home Core Set measures for FFY 2020 that were also included in FFY 2021 and 2022 measure sets. FFY 2021 and FFY 2022 data will be available in early 2024. FFY 2020 data are the most current data available at this time. When the FFY 2021 and 2022 data are available, it will be shared with the Workgroup.

The dark green bars indicate the number of programs using Core Set specifications; and the lighter bars indicate programs that reported the measure but deviated from Core Set specifications, such as using alternative data sources or different populations. The most commonly reported measures were emergency department visits, follow-up after hospitalizations for mental illness, and inpatient utilization. The least-frequently reported measures were screening for depression and follow-up plan and controlling high blood pressure. Of note, the Ambulatory Care Emergency Department Visits measure, or AMB-HH, is being retired by NCQA for HEDIS measure year 2024. This aligns with FFY 2025 Health Home Core Set reporting.

The most common reasons for not reporting these measures included a lack of access to medical records or electronic health records and lack of required codes and administrative data. In addition, small Health Home populations and continuous enrollment requirements limited the number of enrollees that were eligible for some measures. Next slide.

Now we're going to turn it back to Sara Rhoades at CMCS to highlight the 1945A Health Home State Plan Option. Sara, it's all yours.

Sara Rhoades:

Thank you. Hello, everyone, again. I just want to differentiate. We've been using the titles "1945" and "1945A Health Homes" to refer to the two different Health Home programs, and 1945 and 1945A just reference the part of the Social Security Act where they're located. Okay, so just wanted to get that out of the way.

The overview – so the Accountability Act of 2019 authorized States to cover Health Home State plan benefits for Medicaid-eligible children with medically complex conditions and enacted section 1945A of the Social Security Act. Under section 1945, beginning October 1, 2022, States had the option to cover the Health Home services for Medicaid-eligible children with medically complex conditions, as defined under § 1945A(i) of the Act. There was a State Medicaid Director letter that regarded this information on a 1945A Health Home benefit which was released on August 1, 2022; and there's a link there where it can be found. Next slide.

The goals of the 1945A Health Home Program is to coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times, and develop an individualized, comprehensive, pediatric family-centered plan for children with medically complex conditions that accommodates patients' preference. Let me stop right here for one second. You will notice that 1945A is specifically-targeted at age. Unlike 1945, this is specific to the pediatric population, which we are defining as under the age of 21. Next slide.

The goals of the 1945A program continue. They work in a culturally and linguistic-appropriate manner with the family of a 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. To coordinate access to sub-specialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic treatment and critical care levels as medically necessary. Palliative services if the State provides Medicaid – oops, this looks like it's cut off a little bit – if it's under the Medicaid (inaudible). Next slide.

Coordinate care for children with medically complex conditions to out-of-State providers furnishing care to the maximum extent practical for the families of such children and where

medically necessary in accordance with the guidance issued under subsection (e)(1) under section 431.52 of Title 42 of the Code of Federal Regulations. Next slide.

This is a big focus of 1945A that is way different than 1945. They're very similar programs as far as they're both care coordination models; they both pretty much provide similar services; but the eligibility criteria is different. So under 1945A(i)(1) of the Act, a "child with medically complex conditions" must be under 21 years of age and eligible for medical assistance under the State plan, or a waiver of such plan, which CMS terps to include eligibility under 1115 demonstration. Next slide.

Under 1945A(i)(1)(A)(ii), a "child with medically complex conditions" must have at least – so these are the key things: One or more chronic conditions. It's really three things that allows a child to be eligible for this program. Having 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. The second part of that – and it also requires some kind of intervention – the use medication, durable medical equipment, therapy, surgery, or other treatment. The other criteria that could have a child eligible for this program would be they have one life-limiting illness or rare pediatric disease, as defined by the Food and Drug Cosmetic Act.

So those are the criteria. This is important to note because this model is eligibility-driven, not condition-driven. 1945, State identifies the conditions that they want to serve, and it's really driven by that. This is if a State takes, one, this benefit and they have children that meet any of these criteria, regardless of what the chronic condition is that has them meet this, they would be eligible for services. So it's really eligibility-driven. Next slide.

These are the chronic conditions. These are in the statute, but it's not limited to these. They just list it: cerebral palsy, cystic fibrosis, HIV/AIDS, blood disease, muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, and other serious emotional disturbances or serious mental illness. Like I said, it's not limited to these. But if a child meets that eligibility requirement, a State would be serving all of these populations in addition to any other ones that they've noted. Next slide.

The process of identifying additional chronic conditions – States should demonstrate to CMS's satisfaction through documentation in their proposal in their State Plan Amendment that they will establish a process for identifying chronic conditions that are not listed in 1945A(i)(2) that meet statutory definition of chronic condition because they are serious, long-term physical, mental, or developmental disabilities or diseases. We added this in, and the reason we did is so that States didn't have to keep coming back in for amendments to add new chronic conditions because we are talking about the most severe medically-fragile children, so there might be only one person in the entire State who has a certain condition. So we didn't want them to have to keep having to come in and amend their SPAs. This process should ensure that a State would cover Health Home services for children who are eligible for these services on the basis of having one or more chronic conditions that are not listed under 1945A(i)(2) but that meet the statutory definition of "chronic condition." Again, this is an assurance that is inside of the State plan so that they can continue to serve additional children that meet the eligibility criteria without having to amend the SPA. Next slide.

1945A Health Home Services – you can see here that they're very similar to the services that are under 1945, care coordination model again. I would note the second bullet there. There's a little bit of addition there, where they have this provision of access to a full range of pediatric

specialty and subspecialty medical services, including services to out-of-State providers and medically necessary. Down on the fourth bullet, this adds in the family support, including authorized representatives; and this is because we are speaking with children. The families are a little bit more involved in this model than they may be in the 1945, which does serve children and adults; but like I said, there's maybe a little bit more family involvement in this model because it's all children. Next slide.

Okay, I will turn it back, thank you.

Maria Dobinick:

Sara, thank you so much for that very, very helpful overview of the 1945A Health Home State plan option. It's a really good reminder of how 1945 and 1945A programs compare as Workgroup members and federal liaisons consider measures for addition to or removal from both Core Sets.

Okay, so this slide and the next illustrate the 2024 Health Home Core Sets. CMS will release the 2025 Health Home Core Sets in early 2024. As the updated measure lists are available, updated resources will be shared with the Workgroup.

This slide shows the 2024 Core Set of Quality Measures for the 1945 Health Home Program. This illustrates which measures are also included on the Child/Adult in 1945A Health Home Core Sets. All of the measures have administrative data specifications, and several also have hybrid and EHR specifications. Next slide.

This slide shows the 2024 Core Set of Quality Measures for 1945A Health Home Programs. This list includes seven measures that align with measures in the Child Core Set and 1945 Health Hone Core Sets. All of the measures have administrative data specifications, and a couple also have hybrid and EHR specifications. Next slide.

Now I'd like to recap the 2025 Health Home Core Sets Annual Review. During that Workgroup, they recommended the removal of two measures from the 1945 Health Home Core Sets Prevention Quality Indicator 92: Chronic Conditions Composite or PQI92-HH, and Screening for Depression and Follow-up Plan, CDF-HH. The Workgroup discussed but *did not recommend* two measures for removal. Controlling High Blood Pressure or CBP-HH, and Admission to a Facility from the Community, AIF-HH.The Workgroup discussed, but did not recommend, one measure for addition to the 1945 Health Home Core Sets. Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update or MLTSS-2.

No measures were discussed for addition to or removal from the 2025 1945A Health Home Core Sets. Please note that this is a summary of the Workgroup's recommendations, and CMCS has not yet formally released the 2025 Health Home Core Sets. They will be available in early 2024. Next slide

We also wanted to make Workgroup members and federal liaisons aware that in July 2023, NCQA announced the retirement of the Ambulatory Care Emergency Department Visits, or AMB-HH measure, for HEDIS Measurement Year 2024. This aligns with FFY 2025 Health Home Core Set reporting. Workgroup members and federal liaisons may want to consider this as they make suggestions for the 2026 Core Sets. Next slide.

Now we'd like to open up the floor for any questions from Workgroup members. Remember to please use the "raise hand" function, and you will be unmuted in turn.

[Pause for questions]

I think I see Dee Brown. Go ahead, Dee.

Dee Brown:

Thank you, I just have a curiosity question. Since 2024, the States – there's mandatory reporting. Are there penalties imposed on the States if they do not or are not able to report certain measures, or is that going to be something this Workgroup considers for additions and removal in the future?

Maria Dobinick:

Thank you, Dee, that was a great question. Sara, I'm wondering if you can answer that for us. Derek, if you can unmute Sara, please.

Sara Rhoades:

Sure, so the penalties are outlined in the rule itself; so it will not be part of this Workgroup. They are – so when the – I will speak briefly on the child and adult side because there's not much time. But there is a little bit more exceptions and wiggle room on that side than the Health Home side because Health Home is actually in the statute as a condition of payment that providers are supposed to be reporting to the State. What the rule does for us, a mandatory measure rule allows us then to make it mandatory for the State to report that information to us. So they should be getting that information already from the provider. With that said, I'm sure CMS will be taking things on a case-by-case basis; but the rule does have outlined in it the penalties.

Maria Dobinick:

Thank you.

Sara Rhoades:

Uh-huh.

Maria Dobinick:

Thank you, and if you could both mute yourselves again. I do believe I see Jeff. Go ahead, Jeff, I think you're unmuted.

Jeff Schiff:

Thanks, I'm curious from – maybe this is for you, Sara – what the number of programs has gone down a little bit. Is that because the program-enhanced FMAP rate expired for those, or do you know why? Then, I know there's been some issues around 1945A program initiation. I don't know if there's any progress as far as folks signing – States signing up for those programs.

Sara Rhoades:

Sure, I can take both of those. So for 1945, we see varieties of reasons why States choose to terminate. Some is exactly what you said; that we have had some States terminate just when the enhanced matches end it. But more likely, we have seen States fold the Health Home-type services into a larger picture, where they're doing some kind of across-the-State, Medicaid-based program and they fold their services into it. We've seen that more than we've seen it be a negative reason, per say, why they would terminate.

Jeff Schiff:

Right.

Sara Rhoades:

Then for the 1945A, we've not had a State take it on yet; but we do have a planning grant request in-house. I think I can mention which State that is. Utah is in-house, where they've requested funding to explore with the planning grant funds. So we do have one there; but, yeah, it has not taken on across the country at all for the 1945A yet.

Jeff Schiff:

Thank you for the information.

Sara Rhoades:

Sure.

Maria Dobinick:

Thanks, Sara and Jeff. I see Libby Nichols. Derek, if you can unmute her. Thank you. Go ahead.

Elizabeth Nichols:

Hi, I just had some clarifying questions. You had mentioned that AMB is retiring from NCQA – or NCQA is retiring AMB. I was trying to understand. It looks like in one slide it was sort of implying that AMB will be removed from the Core Set, but then another slide it looks you were kind of – I was trying to understand whether it's like recommending that someone submit it for removal because of its retiring, or is it automatically being retired because it's no longer going to be a maintained measure?

The other question I have that's kind of in that measure maintenance realm was around colorectal cancer screening. The non-electronic version of that measure will be retiring moving forward; and while I think the Health Home technical specifications I think don't actually include an electronic version of the Health Home version of the colorectal cancer screening measure. So there's like a Catch-22 gray area. if the administrative non-electronic specifications are removed, will electronic Health Home specifications begin; or would that measure also kind of be in the same place as AMB, where that measure is retired and so maintaining a Health Home-specific version would be not quite aligned? I can clarify anything if needed.

Margo Rosenbach:

Libby, this is Margo Rosenbach. I can start off on colorectal cancer screening. To clarify on that, it would not be initially removed. As you said, right now there is a statement that it would be going to electronic only; however, for the Core Sets, we are looking at opportunities to continue to provide paper specs to maintain those for administrative reporting. So that is a work in progress in terms of what the future holds for administrative versus electronic specs, but it would *not* be retired solely because it's moving to electronic specs. But we have every intention of working to retain administrative specs.

Maybe I'll also take the AMB question, and Tricia and Maria can also jump in or Sara. I think the point that was made is that the measure steward is retiring the measure; so historically when a measure steward retires a measure, it is retired from the Core Sets because it's not being maintained by a measure steward. That's not always the case, but I think in this case it's likely. I think the point that was being made is not that you need to recommend it for removal; but if there were another measure that would be suggested to address the same type of issue in terms of ED utilization, I think that was the intent of saying that that is something to keep in mind if the Workgroup thinks that a gap could be left by the retirement of AMB by the measure steward and then from the Core Sets. So I think that was the intent of that statement. Is there – does that answer your question, or anyone else want to add anything from the team?

Sara Rhoades:

This is Sara. I'll just say that Margo is exactly right with it being retired. In the past if there's measures which we can get a steward somehow and we tried to keep a retired – IU is a prime example of that where we were able to find a contact who would be a steward and we think it was being beneficial and heavily reported on. But in this case, I do not foresee that being the case – we'll use the word "case" there. I will note it was also recommended as one of the 1945A measures as well, so it would also be retired from that as well.

Maria Dobinick:

Thank you all so much for that. I'm sorry, Libby, did you have a follow-up?

Elizabeth Nichols:

I think so. So with colorectal, thank you for clarifying some of those things. I realize there's a little bit of a tricky (inaudible) of what we anticipate versus, say, what's going to happen. So I appreciate that insight. With colorectal cancer screening, would it be kind of a similar situation where there's – I'm interested in kind of like spec maintenance over the years. So would the goal be to have an external source kind of maintaining those administrative specs?

Margo Rosenbach:

I think that that is something – probably in terms of thinking about the 2026 Call for Measures, I don't think that's something that – probably you should assume that there will be maintenance of those facts and not concern about who will do it. I think that's under discussion at this point. But I think for purposes of the Call for Measures, assume that colorectal cancer screening will continue to be maintained at least for the time being, including 2026, by the administrative

specifications will continue to be available. I think we should probably move on to Jeanne next. We appreciate all the questions, but we're starting to run a little short of time.

Elizabeth Nichols:

Thanks.

Maria Dobinick:

Derek, if you could unmute Jeannine, please. Jeannine, you're unmuted.

Jeannine Wigglesworth:

I see that AMB as a very important measure, as we are – one of the initiatives of the Health Homes is to reduce a higher level of care. So I just wanted to hear again why the AMB was being retired, what were the reasons, and if you guys had any other measures kind of in the hopper to replace it.

Maria Dobinick:

Thank you. So again, the reason it's being retired is that NCQA is retiring that measure. As far as any measures that might be coming down the pipe, we look forward to hearing what the Workgroup and federal liaisons have to present.

Jeannine Wigglesworth:

Did NCQA say what reasons they were retiring it though? I thought I heard earlier – was there a lack of information?

Maria Dobinick:

Yes, we – oh, sorry to cut you off, Jeanne. It's cutting up a little bit. Yes, we do have that information; and we can send the rationale from NCQA along with the information that you all receive for the Call for Measures tomorrow, okay?

Jeannine Wigglesworth:

Great, thank you.

Maria Dobinick:

Yes. Last but not least, Dee.

Dee Brown:

Thanks again. I just wanted to make a comment on the 1945A and what States are doing what just because I understand. Missouri is intending to adopt it. They have not submitted their SPA yet, but they're intending to do so over this next year and in discussion with their Health Homes. Then, Washington in the legislative session added language. It hasn't been passed yet, but the State of Washington did include the 1945A Children's Health Home in their legislative language

through the Legislature. But it hasn't been improved yet. I just wanted to give you that information.

Maria Dobinick:

Thank you, Dee. As we have more information, we will absolutely certainly make sure that we pass everything along to our Workgroup members.

Dee Brown:

The only comment is that I think there is some concern from both providers and others – the (inaudible) mechanism and how that would play out. I think it's difficult because there is no real history associated to looking at that. So the financials are of concern to a large stakeholder group.

Maria Dobinick:

Sure. Sara, I see you are unmuted.

Sara Rhoades:

I was just going to say that's great to hear. So it sounds like we may have three on the horizon.

Maria Dobinick:

Perhaps, yeah.

Dee Brown:

Okay, and the payment mechanism is not for this call. I will just say that it will be recorded on the (inaudible) internally, the same as 1945. It's just a different line item – at least on this end.

Sara Rhoades:

Exactly, I mean, it's something that they have to figure out. I think that's where everybody's getting a little bit hesitant on how will they do this. So I think there's an intent to do it. I just think people don't know how they're going to. So send them my way for more information to set up calls with them.

Maria Dobinick:

Thank you, everybody, so much. We still have a good chunk to cover, so on that I am going to hand things back over to Trisha. Great conversation, everybody.

Patricia Rowan:

Yeah, thanks. I will fly through these next two slides, everybody. So hang onto your hats. Next slide, please.

These next few slides provide a recap of our gaps discussion from last year's Workgroup annual review process. As we mentioned before, this process is designed to identify gaps in the

existing Core Sets and suggest updates to strengthen and improve them. Every year we have a conversation about what those gaps might be. We do not come to a consensus about the gaps, nor do we prioritize those gaps or assess the fit or feasibility for the Core Sets. Nevertheless, this information may be helpful as a starting point as folks consider measure suggestions.

The slide illustrates some of the measures' specific gaps that were highlighted during last year's meeting, including well-child visits and immunizations; screening for social determinants and social drivers of health; connections to services; measures for children with special health care needs; screening resiliency at first childhood experiences and social (inaudible) needs; developmental screenings and diabetes management. Next slide.

Continuing with our synthesis, this highlights the measure concepts related to Health Home program delivery, around the development of comprehensive care plans, care coordination and particular member experience and family experience; effectiveness of care management; a beneficiary's ability to access services and whether their needs are being met. The Workgroup also considered some methodological considerations, including around data sharing between providers, Health Home program managers, and States; harmonization of measures to facilitate more feasible reporting; and member and caregiver relationships. Next slide, please.

All right, so the criteria for suggesting measures for addition and removal are the same as we've used last year and the last couple of years. They fit into three areas, which are: minimum technical feasibility, actionability and strategic priority, and other considerations. In order to for a measure to be discussed by the Workgroup during the voting meeting, any measure suggested for addition must meet all the criteria within the minimal technical feasibility area. Next slide.

Okay, I'm not going to go through all of this. I'm going to really focus on those minimum technical feasibility requirements since, as I said, those are really important for any addition suggestions.These requirements help us ensure that if a measure is added to the Health Home Core Sets, States will be able to calculate that measure. So measures must be fully developed. They must have detailed specifications that enable for production at the program level. They must be tested in State Medicaid or CHIP programs or in use by one or more Medicaid or CHIP programs. There needs to be an available data source that contains all the elements needed to calculate the measure, including an identifier for Medicaid beneficiaries. The specifications should allow States to calculate the measure consistency across Health Home programs, and they must include specifications and co-sets that will be provided free of charge for State use in the Health Home Core Sets. That is a determination that CMS uses, so that's not something the Workgroup needs to consider. Please do review the additional criteria on actionability and strategic priority that are on the slides. These will be included in the materials that we send out to Workgroup members after this meeting. So please take a close look. If you have any questions, reach out to our team. Next slide.

These are the criteria for suggesting removal of measures. We ask that Workgroup members look through the current measures and consider whether any measures no longer fit the criteria for being included, and we've provided criteria for removal which reflect reasons that measures may no longer meet the criteria. Again, under technical feasibility, this might be States are having difficulty accessing the data or if they're not reporting the measure consistently or it's being retired like the AMB that we talked about. There are other considerations also under actionability and strategic priority and other considerations. So we encourage all the Workgroup members, especially our new members, to review the supplemental information that we will be

providing tomorrow along with the Call for Measures opening. About the measures that have been previously discussed by the Workgroup and either not recommended for removal or recommended for removal but ultimately retained by CMS. We understand that circumstances can change over time, but we do suggest becoming familiar with and building on prior Workgroup recommendations. Next slide.

As part of the Call for Measures, Workgroup members and federal liaisons will have the opportunity to suggest measures for removal or addition from the 2026 Medicaid Health Home Core Sets. That process will begin tomorrow, February 1st, when our team will send you an email with instructions on how to suggest measures. Measure suggestions are due on Wednesday, February 29th, by 8:00 p.m. Eastern Time. So that's Leap Day this year. We encourage you to reach out if you have questions about the process, the criteria, the submission forms, or any potential measures. Next slide.

The information that we send out tomorrow will include a wealth of information that you can use to inform your measure suggestions, many of which are listed here on the slide. Next slide.

We also have several (inaudible) and several tips for submitting measure suggestions, really emphasizing that the form you fill out is the most important piece of the consideration. So these tips, again, will be included in your packet. Please be sure to take a close look, and let us know if you have any questions. Next slide.

All right, now in just a very, very short amount of time since we're almost out of time, Kim and Jeff, we'd like to still give you the opportunity to share some remarks with the Workgroup. Kim, do you want to go first? Kim Elliott, can you raise your hand; and we'll make sure Derek unmutes you? There we go. Derek, can you unmute Kim?

Kim Elliott:

Hi, yeah, I'm really looking forward to working with all of you. I know we only have a couple minutes left, so I'm just going to say that this is really a great opportunity. When I start looking at these measures, I really look at measures and how they're really going to impact the populations served through the Medicaid Home Health Program and really address the gaps that we're looking at when we're thinking about adding new measures. It's such a great opportunity. With such a limited amount of time left, I think I'll turn it over to Jeff. But I'm really looking forward to working with all of you.

Jeff Schiff:

I'll second Kim's comments really quickly and just say that I think this set of measures has really the importance for these individual clients. But I'll also say that when (inaudible) the 1945A came on the scene, it really raised awareness of kids with medical complexity in the Medicaid program. I'm really proud of the work that has occurred around that. Then, the measure set hopefully will follow from that, although we certainly – as you look at measures, we'd love to see some more measures for kids with medical complexity. They are difficult; I won't deny that.

The last thing I'll say is just that I've been at this, as many of you have, for a long time; and we always are trying to balance parsimony versus completeness. As we go forward, I guess I'll say I encourage folks to spend some time thinking about submitting measures. Then, when we get

to our meetings where we vote, it will be important to consider both that sort of balance for the providers who have to submit their measures to CMS.Thanks, and I'll turn it back to you guys.

Patricia Rowan:

Thanks, Jeff and Kim; and thanks again for agreeing to be our Co-chairs this year.Just in the interest of time since we're going to skip this second opportunity for Workgroup questions. You can definitely reach out to us tomorrow when you get the Call for Measures material. We do want to make sure we have time for public comment. So if there's anyone on the call who would like to make a comment who is not from the Workgroup or federal liaisons, please raise your hand now.

[No response]

All right, I am not seeing any. Let's go to the next slide.

This mostly recaps information that I've already shared. You will hear from our team tomorrow with instructions on the Call for Measures. This group will reconvene on June 5th. Registration for all meetings is already on the website, so please register and get those on your calendar now. Next slide.

These are links to resources that will be in your packet. Next slide.

All right, folks, I know we flew through a lot of information. If you have questions or want to chat with our team, our email address is on the slide. It's MHH, for Medicaid Health Home, Core Set Review at Mathematica dash mpr.com [MHHCoreSetReview@mathematica-mpr.com]. Please don't hesitate to reach out to us and thank you for being here today.

Take care, everybody, bye.