

**2028 Medicaid Health Home Core Sets Annual Review:  
Meeting to Review Measures for the 2028  
Health Home Core Sets  
September 15, 2026, 11:00 AM – 4:00 PM ET**

**Nidaa Ekram**

Hello, everyone. My name is Nidaa Ekram, and I'm pleased to welcome you to the Medicaid Health Home Core Sets Annual Review Meeting to Review Measures for the 2028 Core Sets. Before we get started, we wanted to cover a few technical instructions. Next slide. Closed captioning is available in the WebEx platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Control-Shift-A on your keyboard to enable closed captioning.

All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for workgroup members and the public to make comments. Workgroup members will be able to unmute and mute themselves. However, to make comment, we ask that you 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. Please wait for your cue to speak and remember to mute your line when you're done speaking. Also, please lower your hand when you have finished speaking by following the same process you used to raise your hand. All other attendees should follow the same procedure of using the raise hand feature in the lower right-hand corner of the participant panel.

You will hear a tone when you are able to unmute. Please wait for your cue to speak. Then unmute and remember to mute your line when you're done speaking. Also, please lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this webinar. Please use the Slido Q&A feature if you need support. When you send us a question via the Slido Q&A feature, your question will say waiting for review. Please click the word "Replies" under your question to see our response. Next slide, please. If you have any technical issues during today's webinar, please send a message through the Slido Q&A function located in the Slido panel on the bottom right corner of your screen.

If you're having issues speaking during workgroup or public comments, please make sure you are also not muted on your headset or phone. Connecting to audio using computer audio or the "Call Me" feature in WebEx are the most reliable options. Please note that call-in only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name in the platform. Next slide, please. Let's take a moment to review today's agenda. After the introductions, we will move into a brief overview of the health home program and the Core Sets. Next, we will recap the approach to the measure review and the voting process, including the criteria for measure review. Following that, we will discuss the measures that were suggested for addition to the 2028-1945 and 1945A Health Home Core Sets.

There were no measures suggested for removal from either of the 2027 Health Home Core Sets. Following the workgroup discussion and opportunities for public comment, the workgroup will vote on each measure. After the vote, we will transition into discussions to inform future Core Sets, including the gaps discussion and the workgroup's reflection on measures and future directions. We will close the meeting with a final opportunity for public comment and a recap of next steps. With that, I'll hand it over to Emily Costello.

## Emily Costello

Thanks, Nidaa. Hello, everyone. I'm an Advisory Services Analyst at Mathematica with Mathematica's technical assistance and analytic support team for the Medicaid and CHIP Quality Measurement and Improvement Program, which is sponsored by the Center for Medicaid and CHIP Services. It is my pleasure to welcome you to the Voting Meeting for the 2028 Annual Review of the Medicaid Health Home Core Sets.

Thank you to our workgroup members, federal colleagues, and members of the public for joining us for this virtual meeting. This slide reinforces the objectives for today's meeting. First, we will review the measures suggested for addition to the 2028, 1945, and 1945A Medicaid Health Home Core Sets.

Following the votes, we will engage in discussions related to opportunities for future updates, future measure development, and our always robust gaps discussion. These discussions are key to informing future Core Set workgroups. Throughout, there will be opportunities for public comment. I'd like to pause for a moment and note that we are committed to a robust, rigorous, and transparent meeting process within this virtual format.

That said, we acknowledge that attendees may sometimes experience challenges with the virtual meeting format. I hope everyone will be patient as we all do our best to adhere to the agenda and fulfill the objectives of this meeting. Some of you may be wondering why we are not using video for this meeting. As we have mentioned previously, we found that some individuals in some locations do not have sufficient internet or Wi-Fi bandwidth to support video. To ensure full participation by workgroup members and the public, we want to mitigate the technical difficulties that sometimes arise with using video. I also want to remind the workgroup members of a few ground rules for participation today.

First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a workgroup, however, you are charged with recommending Core Set updates as stewards of the Medicaid Health Home Program as a whole, and not from your individual or organizational perspectives. Please keep this in mind during the discussion and voting. Second, we know that spending hours in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning back from the break so that we can have everyone present for the discussion and voting on the measures. Related to that, we want to make sure that all workgroup members who wish to speak may do so.

When you want to make a comment or ask a question, please use the raise hand feature on WebEx, and we will make sure you have a chance to speak before we move on. Finally, we want to remind public attendees that we will have designated opportunities for public comment and ask that you save your

comments until we reach a public comment period. Next slide. I would now like to introduce our workgroup co-chairs, Jeannie Wigglesworth and Kim Elliott, to make some of our questions. Jeannie, if you don't mind going first.

## **Jeannie Wigglesworth**

Good morning, everyone. My name is Jeannie Wigglesworth, and I am from Connecticut. A little bit about my background. I have worked in behavioral health for about 34 years in a variety of roles with, you know, a variety of different populations. And it is an absolute privilege to serve as a co-chair for this committee. And I'm honored to be part of the conversations that can influence how our members receive care and how we improve whole health, whole person's health. And I feel in many ways the Health Homes have been trailblazers for integrated care.

Long before integrated care became a broader focus across health care, health homes were already bringing in that behavioral health, medical care, SUD services together and learning what it takes to coordinate care across systems. And I feel that gives us the health home family here an important perspective as health care health care continues to move forward whole person care. I also want to say I believe strongly in this process and in the importance of these measures because I have seen their impact firsthand in Connecticut.

When Connecticut first started its behavioral health home, it was about 11 years ago. And we took on the challenge of bringing behavioral health, medical, Medicaid data together. We had to figure out how to collect it, clean it, interpret it. And, you know, most importantly, turn it into meaningful information for providers to use to improve care. And I'm sure as all of you know, it was difficult.

There was no roadmaps. But looking back, I could see how just the process itself fundamentally changed how we viewed our data and the services we were providing to our members. The measures and management reports we developed began influencing how we thought about integrated care well beyond the health homes. Other care line programs began looking at outcomes through similar lens. And the health home providers began applying practices developed through the health home program to serve other members in their agency.

By looking at the data collectively across all the providers in the health home, it created a common platform for health home providers across Connecticut to compare experiences, discuss what was working and what was not, and identify opportunities for improvement, not only within their own agencies, but across the larger Connecticut health care system. And then as the reporting expanded to mandatory reporting for also Adult and Child Core Sets, the conversation spread even further.

Our substance use initiatives began looking at measures like IET and FUA and outcomes related to opioid use disorder. Our clinical team began sharing FUH and FUM outcomes with the hospitals and discussing timely follow up after hospitalization. Programs serving children and families began educating parents about the metabolic monitoring when their children are prescribed an antipsychotic medication. And from feedback, many of the families had no idea.

So they became much more important than trying to figure out how to collect the data and report. They just really created a broader platform for conversations about data outcomes and interventions and the

connections among different programs and provider levels. And it kind of pushed back our usual business of silos when providing different levels of care. And it made us really think as a whole, like how are the health home members that we are serving also touched by different programs, the medical, the substance use, you know, and how can we better coordinate our efforts so that work of one program strengthens the work of another.

Of course, you know, in Connecticut, we have a lot to learn still, particularly about integrating different data sources. But even with the relatively small amount of supplemental data we have today, we've seen, you know, how powerful that integration of data can be because it gives us more of a complete picture of our members. It helps us understand how physical health and mental health and substance use conditions interact.

It allows us to examine outcomes better through health equity lens, asking why some populations may experience care and outcomes differently than others. And it helped us create information that can support multiple initiatives rather than separate approaches for each program. And most importantly, I feel like the process of integrating data showed us how much we still didn't know. So, as we discuss measures today and some important information we may discover may be difficult to obtain because of limitations of data availability and technology and standardization for the way our health care systems are structured, I hope we can use this committee not only to recognize those challenges.

But also, I think if we could use this time to help each other address some of those data challenges when we are discussing the methods. So anyway, I'm grateful to be part of this committee and of a much larger effort that we do to focus on helping people live healthier, happier lives. Thank you. And I look forward to our discussion today.

### **Emily Costello**

Thanks, Jeannie. I will hand it to Kim.

### **Kim Elliott**

I think Jeannie's opening really was great. It really points out to us that what we're working on today and what we work on through the core measure set workgroups is really focusing on the people and the outcomes for the people. So, quality of life, quality of health. But really, I just want to welcome everyone to the workgroup meeting. I'm really looking forward to working with you as we discuss the two proposed measures for the Health Home Core Set and of course, the one for the 1945A measure set. Like you, I'm really excited to be part of this important process. I find it particularly meaningful because it really helps shift focus on things that are really important to a population that's being served through health homes.

And I really appreciate the wide range of subject matter expertise that each workgroup member brings to this work. And when I think about the value of the work that we do, I really immediately think about the potential impact our cast on improving outcomes for individuals served through health homes. That's really what this is all about is improving health and outcomes for individuals. We are charged with assessing the 1945, 1945A Medicaid Health Home Core Set measures, identifying gaps in the Core Set and making recommendations that will strengthen and improve the Health Home Core Set. As we review the

proposed measures, we consider whether the measure reflects the population served in the Health Home Programs.

We also discuss whether the states have the data and information available to report the measures. And all of these measure specifications continue to evolve. We're getting much more into digital and electronic measures. So those are things that we really need to be able to think about and capture as we work through this process. We also want to make sure that the measures that are recommended for addition have the ability to be stratified measures and whether the measure bridges any gaps in the Health Home Core Sets. I really want to thank Mathematica because they really do make our job a whole lot easier with all of the resources that they consistently provide to make our work more efficient and effective.

As I evaluated the proposed measure, I considered the qualifications for the measure in the Health Home Core Set, how the use of a measure may meaningfully drive improvement in health care delivery and outcomes for the member, keeping the member as the focus of why we measure performance. Then I considered whether there are actions that can be implemented that are feasible, viable, efficient, affordable to report measures at the program level. I also considered whether the proposed measures address gaps in the Core Sets. It is sometimes challenging to identify measures that meet all of the criteria for consideration for inclusion as a Core Set or as we talk through what our purpose really is to achieve that goal.

The particular measures that have been tested in a state Medicaid program are really the most challenging thing to identify. However, the criteria results in a strong Core Set to drive improvement and improve member outcomes. I'm particularly looking forward to the gap discussion today and the thoughtful profits we use for the discussion. Thank you for your focus and participation throughout the meeting. Your work is really appreciated. Thank you.

## **Emily Costello**

Thank you, both Kim and Jeannie, for your remarks and also for your time and dedication to this workgroup and helping it run so successfully. Next slide. Next, we will introduce our workgroup members and we will review disclosures of interest. Next slide. To ensure the integrity of the review process, we ask that all workgroup members submit a form that discloses any interests, relationships or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict related to the current Health Home Core Set measures or the suggested measures that will be reviewed by the workgroup for potential addition to the Health Home Core Sets. During introduction, members are asked to disclose any interests related to the measures that will be reviewed by the workgroup. Next slide.

When we go through roll call, we ask that workgroup members raise their hand when their name is called. You may unmute yourself and you can say hello, share any disclosures that you may have or indicate that you have nothing to disclose. We also have an icebreaker to start off the meeting. We'd like you to briefly mention one thing that you're looking forward to during today's Annual Review Meeting. When you're finished speaking, please mute yourself in the platform. This will allow you to unmute yourself when you would like to speak during the measure discussions. If you leave and re-enter the platform or find that

you've been muted by the host due to background noise, just raise your hand and we will unmute you. Next slide.

On the next two slides, we've listed the workgroup members in alphabetical order by their last name. When I call your name, you may unmute yourself and begin speaking. If you've also muted yourself on your headset or phone, please remember to unmute your own line to avoid the dreaded double mute. If you have any technical issues, please use the Q&A function in Slido for assistance. So Kim, we will start with you. Please indicate whether you have a disclosure and mention one thing you're looking forward to during this year's meeting.

### **Kim Elliott**

Thank you. Kim Elliott, and I have nothing to disclose. What I look forward to, I think, the most in these meetings, other than maybe the gap discussion, is really the diverse feedback and comments that we receive from every workgroup member. Everyone comes from a very different place, different experiences, and sometimes it really makes me think a little bit differently about the measure. So, I really look forward to the discussions.

### **Emily Costello**

Thanks, Kim. Jeannie?

### **Jeannie Wigglesworth**

Hi, I'm Jeannie Wigglesworth, and I do not have anything to disclose. I want to piggyback off of Kim. I really enjoy hearing from all the different states and their perspectives and how they go about tackling this program. It's just incredibly meaningful to get that type of perspective.

### **Emily Costello**

Thanks, Jeannie. Next, we have Clarissa.

### **Clarissa Barnes**

Hi, this is Clarissa Barnes. I also have no disclosures. Man, I'm glad I'm going earlier because it's going to be getting harder and harder as we get down to come up with something new to say, I think, in terms of what we're excited about. But I actually really appreciate, in addition to the actual discussion, getting insights into how other states and agencies approach quality and, like, their quality sort of areas are structured. As coming from a smaller state, I think that getting a perspective of that is very helpful as we move forward.

### **Emily Costello**

Thanks, Clarissa. Next, we have Jim.

**Jim Brennan**

Hi, Jim Brennan. I also have no disclosures. As a new workgroup member, I'm also interested in finding out how other states are approaching, you know, quality improvement and quality metrics for the Health Home Programs. And just, you know, getting a better perspective on how this workgroup functions as a new member joining. So, I'm taking the place of one of the other Rhode Island people here for the first time this year. So glad to join.

**Emily Costello**

Thanks, Jim. Ari?

**Ari Hauser**

Hi, Ari Hauser. I also have no disclosures to report. I'm most interested in hearing the perspective of others in the workgroup for these measures. In my particular case, my background is as a statistician and as an advocate. I am not involved in running health home Medicaid programs. So, I do have a different perspective and I'm sometimes surprised and grateful to get perspectives with others who are in a different role.

**Emily Costello**

Thanks, Ari. Next, we have Raina.

**Raina Josberger**

Hi. Good morning. This is Raina Josberger. I also do not have any updates on my disclosure statement. And I'm happy to rejoin you all. I had been part of this workgroup a few years back when one of my colleagues was on maternity leave. So it's nice to be back again. And I do look forward also to the discussion. I think it's really interesting to hear others' perspective on their approach to quality as well as how other health departments, other Medicaid agencies, are set up. So, thanks for joining with you today.

**Emily Costello**

Thanks, Raina. Pamela?

**Pamela Lester**

Hello. I have no disclosures and I am looking forward to the gap discussion today.

**Emily Costello**

Thank you. All right. Moving on. Next, we have Johnny.

**Johnny Schultz**

My name is Johnny Schultz. I have no disclosures and just looking forward to hearing more from the experience of the others in the room and interested in hearing and interested in understanding better the intersection between operationalizing the quality measures.

**Emily Costello**

Thank you, Johnny. Next, we have Laura.

**Laura Vegas**

Hello, everyone. This is Laura Vegas. I also have nothing to disclose. And I always look forward to hearing other people's perspectives. In my professional life, I operate mostly in the intellectual and developmental disability space. So hearing the broader impact of health homes is always very helpful and interesting in my work.

**Emily Costello**

Thanks, Laura. I don't believe Janelle is on yet, but when she does join, we'll give her a moment to introduce herself. Next slide, please. We would also like to acknowledge the participation of federal liaisons in the annual review process. The workgroup includes representation from the Administration for Community Living, the Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality at CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, the Office of Disease Prevention and Health Promotion, as well as the Substance Abuse and Mental Health Services Administration.

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

I'd like to acknowledge my colleagues at Mathematica, who are a part of the Health Home Core Set Review Team. Since the call for measures closed in May, they have been very busy gathering information on the measures suggested for addition and developing the materials for the workgroup's review of the measures. Thank you, team, for your efforts. Now I will hand it back to Nidaa to provide an overview of the Health Home programs.

**Nidaa Ekram**

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

The Medicaid Health Home State Plan Option authorized under Section 1945 of the Social Security Act allows states to provide comprehensive care coordination to Medicaid beneficiaries with complex needs. Health Home Programs are intended to integrate physical and behavioral health, along with long-term services and supports. States interested in implementing a health home program must submit a state plan amendment, or SPA, to CMS. States can focus enrollment in 1945 Health Home Programs based on condition and geography, but cannot limit enrollment by age, delivery system, or dual eligibility status.

Each health home program requires a separate SPA, and you'll notice that we refer to program-level performance. Next slide, please.

This slide summarizes the goals of the 1945 Health Home program, including improving care coordination, whole-person care, and improving quality of care and outcomes while reducing costs. Next slide, please. As you can see here, 1945 Health Home Programs are designed for beneficiaries diagnosed with two chronic conditions, those with one chronic condition and who are at risk for a second one, or those with a serious mental illness.

Chronic conditions include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and being overweight. Additionally, chronic conditions such as HIV or AIDS may be considered by CMS for approval. Next slide, please. Now, we are going to highlight the 1945A Health Home state program option. Under Section 1945 of the Social Security Act, states are authorized to cover health home services for Medicaid-eligible children with medically complex conditions, effective October 1, 2022.

A state Medicaid director letter with information on the 1945A Health Home benefit was released in August 2022 and is accessible at the link on this slide. At this time, there are no approved 1945A Health Home program options. Next slide, please. The 1945A Health Home Programs coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times. The programs develop an individualized, comprehensive pediatric family-centered plan for children with medically complex conditions that accommodates patients' preference.

These programs aim to work in a culturally and linguistic appropriate manner with the families of children with medically complex conditions. And finally, to coordinate access to subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic treatment and critical care levels as medically necessary, palliative services if the state provides Medicaid coverage for these services, and out-of-state providers furnishing care to the maximum extent practical for families of such children and/or medically necessary. Next slide.

This slide describes the criteria for eligibility in the 1945A Health Home Program option, including the criteria for enrollment. Unlike the 1945 Health Home Programs, enrollment for this program is based on a child meeting criteria and not based on a specific condition or geographic region. Next slide, please. The core services for the 1945 and 1945A Health Home Programs are similar, as you can see on this slide. In the interest of time, I won't go through all of them. However, it's important to highlight one key difference. That is, care coordination for specialty and subspecialty medical services can occur with out-of-state providers as medically necessary in the 1945A Health Home Program. But these services are not core services for the 1945 program. Next slide.

Core Set reporting is mandatory for all measures for states with approved Health Home Programs in operation for at least six months of the reporting period. So we asked the workgroup members to consider the feasibility and viability of current and future Health Home Core Set measures as mandatory reporting continues. Programs are required to include all measure eligible populations in reporting, regardless of the health home's target population.

Beginning with recently reported 2025 Core Sets, states are also expected to stratify a subset of measures. And stratification will be required for all measures, eligible measures, beginning with 2028 Core Sets

reporting. While there are many good quality measures, we need to keep in mind mandatory reporting requirements. We ask workgroup members to consider the feasibility and viability for all programs to report a measure within two years of the measure being added to the Core Sets for all populations that are enrolled in the health home program. Next slide.

CMS did not add or remove any measures from the 2027, 1945, or 1945A Health Home Core Sets. However, as we mentioned in the prep meeting a few weeks ago, CMS did make some updates to the stratification standards used in Health Home Core Sets reporting. CMS added two new stratification standards to the existing standards of race and ethnicity, sex, and geography.

The new stratification standards are for children in foster care and adults covered under Medicaid expansion programs. These new standards are voluntary for 2026 reporting and will become mandatory beginning in 2027. CMS has a strong interest in understanding quality of care for these populations. And while reporting these two new standards is voluntary for 2026, CMS encourages states to report them to prepare for mandatory reporting in 2027. Next slide, please.

This slide lists the measures that are subject to mandatory stratification for Health Home Core Sets reporting for 2027. As noted previously, beginning in 2028, stratification will be required for all eligible Health Home Core Set measures. So again, we ask the workgroup to consider whether a measure could be stratified as defined by CMS guidance. I will now hand it over to my colleague Hannah to discuss the approach to measure review and voting.

### **Hannah Klukoff**

Thanks, Nidaa. With that foundation, let's take a moment to review the milestones for this year's review and the workgroup's charge. Next slide, please. This graphic is a visual representation of the milestones for the 2028 review process. We convened this workgroup with the Orientation Meeting on April 22nd and opened the Public Call for Measures for the 2028 Annual Review the same day.

On August 19th, we met to prepare for the Voting Meeting and shared the measures that were suggested for addition to the Health Home Core Sets. Today, we are meeting to review the measures suggested for addition to the 1945 and 1945A Health Home Core Sets. After the Voting Meeting, we will prepare a draft report summarizing the workgroup's recommendations. The report will then be made available for public comment in November. The final report, along with additional input from other partners, will be submitted to CMS for their review. The final report will help inform CMS's ultimate updates to the 2028 Health Home Core Sets. Next slide, please.

The Medicaid Health Home Core Sets workgroup for the 2028 Annual Review is charged with assessing the 2027 Medicaid Health Home Core Sets and recommending measures for addition or removal to strengthen and improve the Medicaid Health Home Core Sets. The workgroup should focus on recommending measures for addition that are actionable, aligned, and appropriate for program-level reporting to ensure that measures can meaningfully drive improvement in quality of care and outcomes for Medicaid health home program enrollees. Additionally, the workgroup should recommend removing measures that do not provide states and CMS with meaningful and actionable information about quality of care.

Finally, given mandatory reporting requirements, the workgroup should focus on the feasibility of state reporting by all states for all Medicaid populations. Next slide. Additionally, the annual workgroup is designed to identify gaps in the existing Core Sets and suggest updates to strengthen and improve them. The workgroup must determine if a measure is feasible for reporting and, if so, also consider the desirability and viability of adding the measure to the Core Sets. While there are many good quality measures, we need to keep in mind the perspective that the measures must be feasible and viable for use in program-level quality measurement and improvement in Medicaid Health Home Programs. Next slide, please.

With that grounding in place, let's discuss some big-picture perspectives. This graphic is a visual representation of the concept of multi-level alignment of quality measures. At the bottom, we have measures at the clinician or practice level, which feed into measures at the program, health plan, health system, or community level. Health Home Core Set measures are considered program-level measures because they are for distinct subpopulations within the state's Medicaid program. The Child and Adult Core Set measures are considered state-level measures because they are intended to capture all Medicaid and CHIP beneficiaries within the state. State-level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP programs as a whole.

CMS values alignment of quality measures across programs and levels because it can help drive quality improvement by addressing each level of care so that improvement at one level may lead to improvement at other levels. Moreover, alignment is intended to streamline data collection and reduce reporting burden. Next slide, please. Now we will share a bit more information about the Health Home Core Sets overall to provide high-level context for the measure discussions. All Medicaid Health Home Programs that were expected to report Health Home Core Set measures for 2025 reported all Core Set measures. The 2027 1945 Health Home Core Sets includes 11 measures. There is no target number of measures, either maximum or minimum.

We encourage workgroup members to consider each measure on its own merits according to the criteria we'll discuss. We also encourage workgroup members to consider opportunities to reduce reporting burden by taking into account each measure's value for driving improvement in care and health outcomes and measure alignment across CMS programs. Next slide, please. The 2027 1945 Health Home Core Sets contain six measures. As with the 1945 Health Home Core Set, there is no target number of measures, either maximum or minimum.

All of the measures in the 1945 Health Home Core Set are also used in other federal programs, including other Medicaid Core Sets. There are currently no approved state plan amendments for the 1945 Medicaid Health Home State Plan option. Now, next slide, please. It's important to note that measure stewards update various aspects of quality measures technical specifications each year. Updates can reflect a variety of factors, such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users.

We have done our best to reflect the most accurate and up-to-date information about the suggested measures. The measure information sheets that workgroup members reviewed in preparation for the meeting reflect public information and information from the measure stewards as of August 2026. Though it is important to note that measures may undergo additional updates between now and when the

measure specifications for 2028 Core Sets reporting are finalized. Next slide, please. To help workgroup members review the measures that were suggested, we wanted to recap the criteria for addition. Next slide, please.

In each meeting, we always come back to our established criteria in three areas for assessing measures. Minimum technical feasibility and appropriateness, actionability, and other considerations. We know many of you have seen these slides several times before. However, we have some new workgroup members and public attendees, and the criteria are foundational to the measure discussion. To be considered for addition to the 2028 Health Home Core Sets, a measure must meet all minimum technical feasibility requirements. Next slide, please. On this slide, we show the criteria for addition, starting with the minimum technical feasibility requirements. Starting with the minimum technical feasibility requirements, these requirements help ensure that if a measure is placed on the 2028 Health Home Core Sets, states will be able to report it for each of their approved Health Home Programs.

First, a measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level. It must have been tested in state Medicaid and/or CHIP programs or currently be in use by one or more Medicaid and or CHIP programs, according to measure specifications. It must have an available data source that contains all elements needed to calculate the measure, including an identifier for Medicaid beneficiaries. The specifications and data source should allow states to calculate the measure consistently. The measure should also align with current clinical guidelines and or positive health outcomes. And the measure must include technical specifications, including code sets that are provided free of charge for state use in Health Home Core Sets. Next slide, please.

The second category is actionability criteria. Measures that are recommended for addition to the Health Home Core Sets should contribute to estimating the overall national quality of health care in Medicaid Health Home Programs and be suitable for performing comparative analyses, should address improving health care delivery and outcomes, and should enable assessments of program level progress in improving health care delivery and outcomes in Medicaid and CHIP. Finally, other criteria to consider are, is the prevalence of the condition or outcome being measured sufficient to produce reliable and meaningful results across Health Home Programs? Is the measure aligned with those used in other CMS programs? And will all 1945 Health Home Programs be able to produce the measure within two years of the measure being added to the 1945 Medicaid Health Home Core Set? Next slide, please.

And now, with those criteria in mind, I'm going to provide an overview of the voting process and walk through some practice votes. Voting will take place after workgroup discussion and public comment for the measure under consideration. A yes vote means I recommend adding the measure to the Core Set. A no vote means I do not recommend adding the measure to the Core Set. For each vote, a measure will be recommended for addition to the Core Set if at least two-thirds of eligible workgroup members vote yes. And I'll now hand it over to Maria to facilitate our practice voting.

## **Maria Dobinick**

Next slide, please. Thanks, Hannah. So as a reminder for all attendees, voting is going to be for workgroup member only, workgroup members only. And Emily, if you could bring up the platform. While Emily is bringing up the platform, workgroup members, please make sure that you are logged into your voting

account and have navigated to the Health Home Core Sets review voting page. If you are not already there, you may also use your cell phone and tablet and scan the QR code that's going to pop up here shortly.

As a reminder, if you're not yet logged in, you will need to have access to the email address where you receive correspondence from our team. You will use that email because you will receive a code from Slido to access this section where you can cast your vote. We also suggest that once you are logged in, you keep the voting page open for the duration of the meeting because the new voting questions should appear as we make them available. If at any point we change questions, but you don't see that new question, just refresh your page and it should appear.

We also want to remind you that if you need any help, please refer to Section 1 of the voting guide, which was emailed to you yesterday, or you can connect with us via the Q&A feature in Slido. We also ask that during voting on measures, if for any reason you are unable to submit your vote, you send us your vote through Q&A or to the email address. We also ask that once you have submitted that via Q&A or email, please stop trying to submit the vote. We'll take it from there, and know that your vote is only visible to the Mathematica team.

I'm going to pause for one second and I'm going to hop over into Slido to help see if we can get this practice vote up and running. Again, if anybody has any questions about logging into Slido, let us know via chat or via the email address. You should also be able to vote, so even though we are pulling it up on the screen here, you should be able to go in there and vote now. The vote is, do you prefer dogs over cats? I do see we have five votes. Now we're up to six. We are waiting for nine people total. I am still seeing us at seven votes. So if there are two folks who are having any problems at all with voting, please make sure you drop us a question in the Slido Q&A or via our email.

And again, that voting guide was sent to everybody yesterday and it is Section 1 of the voting guide. We do ask everybody to participate in this practice vote just so we know that when we get into the real votes, everybody is ready to go. And we also appreciate the audience's patience. This is usually the trickiest part. Once we get through the initial foibles of the practice vote, things usually go pretty smooth sailing from here. Okay, it is looking like, Jeannie, we still need your vote. Thanks again to everybody for their patience as we get through this. And if anyone's having any technical issues, please let us know.

### **Jeannie Wigglesworth**

Hi there, it's Jeannie. I was signed in earlier before this meeting. And then for some reason, it's not letting me sign in again. Let me try the phone.

### **Maria Dobinick**

Okay. Yeah, go ahead and try the phone using the QR code. We are still at seven folks. Looks like we are waiting for Jeannie and one other person.

### **Clarissa Barnes**

So, this is Clarissa. I thought I was in and now I'm getting stuck at the part where I need it to send something to my email, but it's not showing up, I guess.

## Maria Dobinick

Okay. Yeah, great. Thanks for letting us know, Clarissa. Please make sure that you are using the emails that you receive all of your correspondence from. And we will double check on our side, what email that is, if you have any questions. You can reach out to us in the Slido Q&A. Also, please make sure you're checking your spam or your junk folders. All right. Again, thanks so much to the audience members. Ah, there we go.

Okay. We are going to -- oh, go ahead. All right. We're actually going to move on to the next vote. And if we are solving problems, we can work on resolving that over the break. So for the results, I do see we have eight votes. And it is 100% confirmed. Our workgroup does prefer dogs over cats. Sorry to the cat folks out there. That would meet the at least two-thirds threshold. We're going to go ahead and vote on the next measure here, the next vote. And this is, are you right-handed? Yes, I am right-handed. Or no, I am left-handed. So if our workgroup members can go in and make that vote again. Again, we are looking for nine votes. We are up to two, four. See, folks, it goes a lot quicker once we get those initial bugs out. Thanks again for all of your patience.

Now, this one I will be interested to know as the mom of a lefty. I'm always interested. Who else is out there smudging up their work and getting crayon and marker and ink all over their hands? We've got two more votes waiting to come in. I'm going to give it about 30 more seconds. There we go. There's our eighth vote. All right. I'm going to show the results. We are 75% right-handed and 25% left-handed. Thank you all so much for going through these practice votes. And thank you again for everybody in the audience as you worked with us to have folks do that practice. Workgroup members, if you were having any questions or concerns, continued foibles through that voting, it looked like we had still one more person.

If they can hang on, please make sure you're emailing us either via Slido or WebEx. For everybody else, we're going to go ahead and take a break. We are going to ask folks to return for the voting section, which, Emily, I'm so sorry, at 12:45. We have a nice, long break. We are going to wait until that 12:45 mark so the folks who are representing the measures, the measure stewards, can join us. So please be on at 12:45. And, Clarissa, I think if maybe you can hold back, we will help you technically troubleshoot through this. Thank you, everybody. And we will see you back here at 12:45 on the dot to discuss the measures.

## Kalidas Shanti

Hello, everyone. Welcome back from the break. Can we go over to the next slide? My name is Kalidas Shanti and I will walk through the first of two measures suggested for addition to the 2028 1945 Medicaid Health Home Core Set. As a reminder, no measures were suggested for removal from the 1945 or 1945A Health Home Core Sets. Next slide, please. The first measure that was suggested during the Public Call for Measures is the Adult Access to Preventive or Ambulatory Health Services AAP measure.

This measure assesses the percentage of persons 20 years of age and older who had an ambulatory or preventative care visit during the measurement period. The measure steward is the National Committee for Quality Assurance, or NCQA. As a process measure, the measure is being considered for the 1945 Medicaid Health Home Core Set. This measure is not currently a measure on the child or adult Core Sets,

but the Child and Adult Core Sets Annual Review Workgroup recommended this measure for addition to the 2028 Adult Core Set. The measure is not being recommended to replace the current measure. The data collection method is administrative. Next slide, please.

The denominator for this measure includes persons 20 years of age and older as of December 31st of the measurement period. The numerator for this measure includes individuals with one or more ambulatory or preventative visit during the measurement period. The HEDIS measurement year 2027 technical specifications include stratifications by age group for this measure. The individual who suggested the measure noted, NCQA, the measure steward, follows a comprehensive measure development process that includes an environmental scan, testing with implementation partners, and guidance from expert measurement advisory panels.

This measure was included in the original HEDIS set and is currently in use by state Medicaid programs. 27 states included the measure and performance measure validation in their external quality review to technical reports for 2024 through 2025, including nine states that operate Health Home Programs. And now I'll hand this back to Maria to facilitate our workgroup discussion for the adults access to preventative or ambulatory health care health services AAP measure.

### **Maria Dobinick**

Thank you so much, Kalidas. As a reminder to workgroup members and federal liaisons, you may unmute your lines if you wish to speak. Please also remember to say your name before making a comment. As we preview during the prep meeting, we would especially like to hear from our state workgroup members who have experienced reporting this measure for other Medicaid programs.

So at this time, if there are any members of the workgroup who would like to make a comment or kick off our discussion on this measure, please raise your hand. I know it's always tough to be the first to raise your hand and speak. Raina, thank you so much. I saw your hand first. You may unmute yourself. Please remember to introduce yourself and then go ahead.

### **Raina Josberger**

Good afternoon. Hi, this is Raina Josberger. My comment to this measure would be I don't know if the person who suggested it for addition provided rates of performance of this measure because my recollection is it's fairly high. The rates of this measure are fairly high, and I would expect for members of health homes, it would be even higher because it is including, as it stated, all ambulatory visits. So my expectation is fairly high, very good performance. So I'd be interested to hear if they gave us an answer as to why they were suggesting its addition and the need for that.

### **Maria Dobinick**

Thank you. And just to confirm, are you speaking from New York's experience with this measure or just generally in knowledge of the measure?

**Raina Josberger**

In general knowledge. I'd have to look up our rates specifically, but I think it's very high, so I would expect health homes to be even higher. I don't know it at a health home level. I'm just speaking generically at this measure in terms of performance.

**Maria Dobinick**

Great. Yeah, thank you for clarifying that. Kim, I saw your hand up next.

**Kim Elliott**

Hi. Hi. Yes, I agree with what Raina just said. It does tend to be a measure that has higher rates, and primarily that is because of the types of visits that are included, and it's not specific to a primary care or specialty care. It's really any ambulatory visit. So it does tend to be a rather high rate for most states, not specific to health home, but just overall.

**Maria Dobinick**

Thank you, Kim. Any other workgroup members with questions or comments about the measure? Remember, we do want to make sure we're really thinking about understanding the feasibility of reporting, so if anyone has any questions about how the measure is calculated, or if any of the state folks have been able to look at their own rates or have any experiences with this measure, we'd love to hear from you as well.

**Clarissa Barnes**

Hey, this is Clarissa Barnes from South Dakota. It's a similar comment to what's been expressed. I think with the slight variation that I just don't think that this measure actually measures what the label makes it seem like it's measuring because it's not specific to types of services. So I don't know from an applicable - like, I don't know what I would do with this as much, if that makes sense, because isn't specific enough in the way that it's set up.

**Maria Dobinick**

Great. Yeah, thank you for that. And so, Clarissa, just to reiterate, you feel like that perhaps there's a little bit of a mismatch between what the measure is actually measuring and the title, and then furthermore, what you would do with those.

**Clarissa Barnes**

Right.

**Maria Dobinick**

Yep, that's great. Thank you. I believe I saw a comment come in. Jim, if you could go ahead and take yourself off of mute.

**Jim Brennan**

Hello. Yeah, I just wanted to add, if people are interested in performance rates, our MCOs are reporting roughly 80% for this measure on their HEDIS reports. So it is a relatively high performance rate in Rhode Island, at least.

**Maria Dobinick**

Great. Thank you so much for letting us know.

**Jim Brennan**

Not for health home. That's just for the whole Medicaid population.

**Maria Dobinick**

Right. Great. Thank you so much. Kim, I think I see your hand is back up.

**Kim Elliott**

Yeah, I just wanted to say, you asked about like the feasibility, the data sources are really clear in a sense that a relatively easy measure to report. But I keep going back to what a former speaker just said about the outcome. What would you do with the results and how would you make a difference in improving access to care or improving quality of life by understanding if people have had an appointment or a visit with, you know, multiple different types of providers that are included in this measure. So I just struggle a little bit with what you would do and how it would really help improve the care for the member.

**Maria Dobinick**

Great. Yes. Thank you for raising that, Kim. Before we open it up, I also want to offer federal liaisons an opportunity to ask questions or make comments about this measure. Again, if you have something you want to say or a question, please do raise your hand and we will call on you. From there, once you are unmuted, we ask you to introduce yourself before your question or comment. All right. Thank you, everybody. Next slide, please. So now at this time, we'd like to provide an opportunity for public comment on the adult access to preventive ambulatory health services or the AAP measure.

Again, please use that raise hand feature in the bottom right of the participant panel to join the queue and then lower your hand when you are done. We'll let you know when you've been unmuted. So again, this is anybody and we are open to public comment. All right. Thank you, everyone. Before we head into the vote, I am going to give one last opportunity for our workgroup members or federal liaisons to ask a question or make a comment. Please raise your hand so we can see you. And if at any point, as a reminder, folks are having problems or technical difficulties, please remember you can message us in that Slido Q&A panel. Oh, Jeannie, I see your hand up. And then Ari, I also see yours. But Jeannie, if you could go first. And you may unmute yourself. Oh, actually, it looks like Jeannie is back down in attendees. Bryce or Fiona, if one of you could unmute her, please.

**Jeannie Wigglesworth**

Oh, great. Thank you. Sorry about that. So for this measure, again, I kind of agree a little bit with what Kim started to say, we're talking about is that if I have it correctly, you're only looking at one ambulatory visit per year. Am I correct on that? And it does seem as far as -- and every population is different, but as far as like coordinating care and everything that the Medicaid health homes are charged to do, the coordination of care, to me, I feel like one visit isn't as meaningful. I feel like we might be looking for a little bit more of an intense or more frequency or something regarding the ambulatory, unless we are focusing on a certain population that is just like starting to engage with treatment. So I'm not so sure how much that would be beneficial in my group. Thank you.

**Maria Dobinick**

Yeah, thank you so much for that question. And just to confirm, you're asking for confirmation on the frequency of how often those visits are measured. We do have somebody from the measure steward here on the line. Adriana, if you could put your hand up, if that's something that you could address. And then Bryce or Fiona, if one of you can unmute Adrianna. Thank you.

**Adrianna Nava**

Hi, everyone. This is Adrianna from NCQA. So yes, I'm confirming that this is looking for an ambulatory or preventive care visit once during the measurement period.

**Maria Dobinick**

Great. Thank you so much. Anything else, Jeannie?

**Jeannie Wigglesworth**

I think it would be good as a, like, initial engagement measure, kind of like IET where you're first, you're newly diagnosed with an SUD, something like that. I think it would be beneficial. But, again, I'm not sure how it would be beneficial for the entire group that are all at different stages, I guess.

**Maria Dobinick**

Great. Yes. Thank you for your insights on that. Ari, I see your hand up. Thank you for being patient. You can go ahead and unmute yourself and please introduce yourself.

**Ari Hauser**

Sure. Thank you, Ari Hauser. If we are likely to see this measure being reported at about 80%, which, as I mentioned earlier, I don't think that is anywhere near too high for usefulness. There's a lot of quality measures that we want to be high, 90% or ideally 100%, but that's never possible, for which, you know, measurement in this range is typical and desired to be higher.

I do understand that the criteria for, you know, getting a positive result on this measure is just one visit, which is often not sufficient. But we can presume that if at an 80% rate, that's a maximum for multiple visits. So it suggests the true level of performance is even lower, which I guess it's not a perfect measure,

but it gives it a stronger case for inclusion in one sense, because they're sort of overestimating the true performance if what's needed is multiple visits for many participants.

### **Maria Dobinick**

Thank you so much for that perspective. I appreciate that. Before we go into voting, this is our last chance for questions. We do have the measure steward here on the line, so if there were any other technical questions, she is available. Also, any last thoughts before we go into the vote? And that can be from the workgroup members, federal liaisons, or members of the public. All right. Well, with that, I am going to hand it back over.

Actually, I'm not going to hand it over. I'm going to ask Emily to please pull up the Slido so we can prepare for our vote. Workgroup members, as we go into this vote, if anyone has any technical issues, again, I ask you to please make a comment in Slido or email us.

So let's go ahead and vote. Should the adult's access to preventive ambulatory health services AAP measure be added to the 2028 1945 Health Home Core Set? The options are, yes, I recommend adding the measure to the Core Set. Or no, I do not recommend adding the measure to the Core Set. Voting is now open. If the question does not appear on your voting page, please refresh the browser. We are only expecting nine votes, and we are at nine votes. I'm going to wait for the preliminary confirmation on the back end. Thank you all so much for the quick vote and for everyone's comments and thoughtful questions.

All right. Emily, if you could -- oh, we're going to go back to Emily's sharing, and we're going to share with the preliminary results. Okay, Emily. Okay. The results are no, I do not recommend adding this measure to the 1945 Medicaid Health Home Core Set at 67%. That does not meet the threshold for recommendation. Thank you, everybody, for your conversation and your vote. Emily, you can go ahead and close that out. So at this time, because it was not recommended for addition, if anybody -- we typically have a debrief. So if there are any additional comments or statements, questions by the workgroup members about why you did not vote for this measure, we can open it up at this time, if anybody has any additional comments. I think -- Jeannie, is your hand freshly raised?

### **Jeannie Wigglesworth**

It is. Thank you.

### **Maria Dobinick**

Yes, ma'am.

### **Jeannie Wigglesworth**

Yeah, I have a question for the group. When we calculate these measures using, you know, claims, we're not allowed to share member-level data back to the providers. And I don't know if that was true for other people, because for this measure in particular, this would be great on member-level, right? Because then you could see actually who didn't have one. But I don't know if that's true across different states or if

they're able to do that or not. But in Connecticut, we're not allowed to share member-level from claims. I'm just curious.

### **Maria Dobinick**

Yeah, thank you for that question. Does anyone have an experience with that or a quick response before we hop into the next measure?

### **Jeannie Wigglesworth**

That's okay. I was just curious. That's all.

### **Maria Dobinick**

No, that's fine. And if anybody thinks of anything while we are going through, I'm happy to bring this back up and raise it during the gaps discussion. And, Jeannie, just to confirm, you're speaking about sharing it back to, like, the providers, like the health home providers themselves.

### **Jeannie Wigglesworth**

Yeah, it is. Because we get most of our information, we do get quite a bit from their EHRs. It goes through into our state DMHAS system, and then DMHAS sends it to us. So when things are outside of some of the services they may provide, and they're especially particular about the 42 CFR, anything to do with substance use, we are not allowed to share. So again, like, some of these measures would be fantastic on a member level, well, especially for smaller. I don't know.

Our population tends to be, like, around 6,000 to 7,000 with 14 providers. But if they were, you know, if they were provided a list that didn't have any, that would be important. And the other thing, too, is with the health home, they're required to have at least one service a month. So if they didn't have one in the entire year, you know, that would be another quality check issue, too.

### **Maria Dobinick**

Thank you. Thank you for raising that. So thinking about it from a quality perspective and almost like a tracking, right, the expectation that folks would be engaged in treatment, and I think particularly with this measure, the range of opportunities for recording an encounter being indicative of, you know, sort of what's happening at the provider level and that provider-patient contact, provider-beneficiary contact. Thank you. I'm going to give it one more minute before we hop into the next measure, if anybody has any additional comments to debrief. Okay. Thank you all so much for the thoughtfulness that went into that first vote. I am going to hand it back over to Kalitas to walk us through the second measure for addition.

### **Kalidas Shanti**

Thanks, Maria. I will now walk through the second measure, suggested for addition, long-term services, and supports comprehensive assessment and update. This measure was recommended for addition to both the 1945 and 1945A Health Home Core Sets. Next slide, please. This measure assesses the percentage of participants receiving Medicaid fee-for-service or managed LTSS age 18 years and older,

documentation of a comprehensive assessment completed in a specified timeframe, which includes documentation of core and supplemental elements.

The specifications for this measure include a version for Medicaid fee-for-service LTSS participants and a version for Medicaid-managed LTSS participants. The measure steward is CMS. This is a process measure. This measure was recommended for addition to both the 1945 and 1945A Health Home Core Sets. This measure is not on the child or adult Core Sets and is not intended to replace an existing measure. The data collection method is hybrid, and the measure is calculated using case management records and administrative data.

This measure is based on a review of Medicaid LTSS participant case management records selected via a systematic sample drawn from the eligible population. Next slide, please. The measure reports two numerators, the assessment of core elements and assessment of supplemental elements. First rate assessment of core elements is the number of Medicaid LTSS participants who had either of the following. For new participants, an LTSS comprehensive assessment completed within 90 days of enrollment with all 10 core elements documented, or for established participants, an LTSS comprehensive assessment completed at least once during the measurement year with all 10 core elements documented.

The 10 core elements are listed on the slide. And again, this rate assesses whether Medicaid LTSS participants had an assessment that included all of the listed elements. Next slide, please. This slide shows the second rate in this measure. Rate two assessment of supplemental elements is the number of Medicaid LTSS participants who had either of the following. For new participants, an LTSS comprehensive assessment completed within 90 days of enrollment with all 10 core elements and at least 12 supplemental elements documented.

For the sake of time, I will not read all 15 supplemental element options, but they are listed here on the slide for your reference. Next slide, please. For both rates, the assessment must be a discussion with the participant in the participant's home and must be performed face-to-face via telephone or via video conference. Assessment in a location that is not the participant's home is not permitted except in the following circumstances. The participant was offered and refused the in-home assessment. The participant is residing in an inpatient or institutional facility during the assessment period or the state policy regulation or the state guidance or other state guidance, the participant from a requirement for in-home assessment.

The current specifications for this measure and the 2024 LTSS technical specifications and resource manual include stratifications by age group. The individual who suggested the measure noted it has been tested in state Medicaid and CHIP programs and is currently in use by at least one state. The individual noted that the testing of this measure included the Medicaid-managed LTSS and fee-for-service LTSS subpopulations. This measure is included in the reporting requirements for the 41 Money Follows the Person MPF grantees. And now I'll hand this back to Maria to facilitate our discussion of the LTSS comprehensive assessment and update measure. Next slide.

**Maria Dobinick**

Great. Thank you so much for going through that again, Kalitas. We really appreciate that walkthrough. Just as with the first measure, I'm asking for workgroup members to kick off this discussion. So if there are any workgroup members, as well as federal liaisons, in particular, if there are any folks who have experience calculating this measure, we ask you to please raise your hand. If you're a workgroup member, you should also be able to unmute yourself. We will start with Laura. I see you first. From there, we'll go to Kim and then Raina. Laura, please introduce yourself.

**Laura Vegas**

Thank you so much. This is Laura Vegas. I work chiefly in the IDD LTSS sphere, and we've been grappling with this measure for quite a while. And one concern that we have consistently is what might be missing from the measure. We know that a comprehensive assessment and care plan is of utmost importance. For people who receive LTSS, I would want us to be thinking about whether we are actually measuring a person-centered assessment and planning process, and not just simply whether an assessment and plan were completed.

So for example, does the process identify the person's goals, the preferences, their strengths and their support needs? And this feeds the resulting plan, which is, you know, a person-centered plan. And so it would be difficult to develop a good person-centered plan without those components included in the assessment process. So that's my comment about this measure, and I appreciate you taking my comment.

**Maria Dobinick**

Thank you, Laura. Thank you for that experience and perspective on the measure. We appreciate it. Kim, go ahead. You may unmute yourself, and please introduce yourself before your comment.

**Kim Elliott**

Sure. Kim Elliott. I work for an external quality review organization, and I do work with states on performance measure validation. One of the core components of the health home, of course, is the care management and making sure that care managers are taking into account member preferences and making sure that all of the recommended care services that are recommended for that member are being included in the care plan. One of the things I like about this measure is it really forces that documentation process and really having those active discussions with the member, the family members, caregivers, about what the member's preferences are for the different types of care and services that they're in need of and documenting it, of course, in a care management system.

And as the prior speaker mentioned, creating that care plan for the member. I do think it's a somewhat challenging measure in that you really need to be able to identify which fields in a care management system the documentation comes from consistently. And I have found from reviewing and auditing this measure that it's not usually the easiest the first year, but it gets easier and easier to report the measure over time.

And the results, I think, do lend themselves to really making some significant improvement in having those conversations and making sure the member preferences are documented in that care management system so that the member does get connected to the care and services that they need. So for that reason, I like the measure.

### **Maria Dobinick**

Thank you, Kim, for your comments and also, again, for your real-life experience with this measure. I appreciate that. Raina?

### **Raina Josberger**

Hi, Raina Josberger from New York. So I can share our perspective of this measure because we have just finished calculating this measure for reporting to the HCBS Core Set. We've not yet reported since that system has not yet opened, but we have received our response set back from our EQR, who's been reviewing all these records. So we don't know our performance yet. We don't have our rates calculated. I don't know where the other 40 states and territories that are reporting this first year, as part of MFP grantees, where our range of results will be.

I've heard they will be quite different across that spectrum. So I would encourage just pausing and waiting to see where results are, particularly this first year, as it relates to state reporting on this measure. Because, as somebody before stated, it has been an enormous amount of work this first year. We've had two samples, one for managed care, one for fee-for-service. The enormous amount of record collection and record review for both the assessments and the person-centered service plans. Some states are sitting in better positions for that than others. So it'll be interesting to see how those results come out.

But I think to drive it down to that health home level, I would caution until we see the results actually at a statewide level before we drive down to more specific groups. Because these health home members who are receiving HCBS are actually included in our larger sample. So we will be able to have some of that insight at a state level if we did drive down to that health home. But we really don't know any of that quite yet. So I don't know where that need is or that gap is.

### **Maria Dobinick**

Great. Thank you so much, Raina, for those insights. And, again, that direct experience is so very helpful for everyone to hear. Are there any other workgroup members with questions about the measure or thoughts, either for your fellow workgroup members, the measure steward? Jeannie, I see your hand up. Go ahead. And you should be able to unmute yourself.

### **Jeannie Wigglesworth**

Yep. I was able to, thank you. Raina, I just have a question. Maybe in layman's terms, how are you collecting the data?

**Raina Josberger**

So for LTSS-1, we do have a very comprehensive assessment in play in New York State. So we are leveraging the interRAI Community Health Assessment and have been for well over 10 years. So we have a very sophisticated assessment system in place. So LTSS-1 is not as much of an issue, though we are requiring all entities to give that assessment to our EQRO. So we don't get involved. So the managed care plans have to provide it to the EQRO as well as all of our fee-for-service entities. So the NHTD, TBI, all those programs have to then give that information to the EQRO as well as the person-centered service plan. So they are providing all that information for review.

**Jeannie Wigglesworth**

And how are they delivering the aggregate data? I'm just curious.

**Raina Josberger**

So it's a flat file. Then our EQRO gave us a flat file at a member level. So we can then calculate those rates.

**Jeannie Wigglesworth**

They all have to have the same variables and format in it?

**Raina Josberger**

Yeah. Yes. Yeah. And everybody does for the assessment. They're all using, I will say, on the managed care side, everybody is using that same assessment instrument. On the fee-for-service side in New York, not everybody uses the same assessment instrument. So there it is more challenging for the reviewers to find those pieces of information because that assessment instrument does vary. It's not standard. It will be. It's getting there. So then when everybody is using a standardized, the same assessment for everybody, it is easier for those reviewers to find that information.

**Jeannie Wigglesworth**

Yeah. That's what I was thinking. We do, obviously, part reviews on our level. But do you implement the same standards that's in here?

**Raina Josberger**

And having it electronic is obviously key.

**Jeannie Wigglesworth**

Yeah, I was just going to say. Right? Yeah. Last question was, so, was it a build out in your system? Is that how you did it? Or did you build the assessment into individuals?

**Raina Josberger**

It's a different system. It is a totally different assessment system that we have that houses many different types of assessments. But there is a nightly feed of those assessments to the entities that are managing

that person's care. So whether it's a health plan or something else, they get nightly feeds of those assessments and how the person performs.

### **Jeannie Wigglesworth**

Yeah. Thank you for that.

### **Maria Dobinick**

Yeah, thank you both for that really rich conversation related to the collection and reporting of this measure. Are there any other workgroup members or federal liaisons who have questions or comments at this time? Again, please raise your hands so we can see you and call on you. Okay, next slide, please. Now we'd like to provide an opportunity for public comment on the LTSS Comprehensive Assessment and Update MLTSS-1 and LTSS-1 measure. Please, again, use that raise hand feature in the bottom right corner of the participant panel to join the queue. And then lower your hand when you are done. We will let you know when you are unmuted.

So again, this is any members of the public who might have a question or comment related to this measure. Please raise your hand. All right. Last call for public comment. I'll also take this opportunity to open it back up to workgroup members and federal liaisons for any final thoughts before we move into the voting. Okay, with that, let's move into our next vote. As Emily pulls up the vote for this, we are going to remind the workgroup members that we will be voting two separate times on this measure.

The first time we'll vote on the addition of the measure to the 1945 Health Home Core Set, or the original Health Home Core Set. And then the second vote will be on the addition of the measure to the 1945A Health Home Core Set. So again, this first vote is for the 1945 Health Home Core Set. The question is, should the LTSS Comprehensive Assessment and Update MLTSS 1 and LTSS 1 measure be added to the 2028 1945 Health Home Core Set? The options are yes, I recommend adding this measure to the 1945 Core Set. Or no, I do not recommend adding this measure to the 1945 Core Set. Voting is open. And if your question does not appear on your voting page, please do refresh your browser.

We are again waiting for nine votes. If any of the workgroup members are having any technical difficulties, which it appears they are not because we are at nine votes, we are going to make a confirmation on our back side related to the preliminary outcome of this vote. So give us one moment to confirm that. See folks, we promised that the voting would get quicker after you get through those first few glitches on the test votes.

All right, we've confirmed on the back end the preliminary votes, Emily. Okay, so the results are with 56%, no, I do not recommend adding this measure to the 1945 Medicaid Health Home Core Set. That does not meet the two-thirds threshold for addition. Thank you, everyone. Next, we are going to move into the second vote for this measure. And again, that is on the addition to the 1945A Health Home Core Set. The question is, should the LTSS Comprehensive Assessment and Update MLTSS-1 and LTSS-1 measure be added to the 2028 1945A Health Home Core Set? The options are yes, I recommend adding the measure to the 1945A Health Home Core Set. Or no, I do not recommend adding the measure to the 1945A Health Home Core Set.

Again, we are waiting for nine votes. If anyone has any technical issues, please reach out via Slido Q&A or the mailbox. We are waiting for one final vote, and there it is. Thank you so much again for that quick vote, everybody. We are going to take a moment and confirm the preliminary vote on the back side, so give us one moment. We appreciate everyone's patience. Okay, we've got confirmation of the preliminary vote. Emily, it's okay to share? All right, the result of this vote with 67% is no, I do not recommend adding this measure to the 1945A Medicaid Health Home Core Set. That does not meet the threshold for addition to the Core Set. Thank you, everyone, for your vote for both the 1945 and 1945A Health Home Core Sets and that measure. Just like the previous measure, because this measure was not recommended for addition, I will open it back up if there are any workgroup members who would like to make a final comment related to why they voted no for addition to the Core Set.

Okay. Thank you, everyone, for a really lovely and robust conversation. Really appreciate the states and the folks who have experience with these measures, talking about their experience. I feel like it really added to the conversation and the discussion. Thank you to our measure stewards who are available today for this discussion. With that, we're going to take a quick 15-minute break. So it is 1:30 on the dot, I could not have planned that better if I tried. We will have everybody back here at 1:45 to do everybody's favorite part, the gaps discussion and thoughts for future consideration for the Core Set. We'll see everybody at 1:45 in 15 minutes. Thank you again for your votes. Welcome back, everyone.

### **Emily Costello**

Thank you for your time and energy dedicated to the 2028 Medicaid Health Home Core Sets. Now we're going to shift gears and look ahead to future Core Sets. Next slide, please. As many of you know, each year the workgroup discusses measure gaps on the Health Home Core Sets, and the gaps discussion from the prior workgroup year informs the call for measures for the subsequent annual review.

The workgroup's identified gaps were presented as part of the Orientation Meeting, and we'll do the same again this year. After the workgroup discussion on gaps, we will have an opportunity for public comment. Next slide. So how are we going to do this? First, we'd like all workgroup members to think about the priority gap areas in the current Health Home Core Sets that could be addressed by the 2029 Public Call for Measures to strengthen and improve the Core Sets. We know over the years we've had lots of conversations and some questions about what measures are out there related to particular topics and themes.

We wanted to keep in mind the purposes and uses of the Core Sets to estimate and understand the overall national quality of health care provided in Medicaid Health Home Programs, assess access to and the quality of health care provided to Medicaid health home beneficiaries, and also use Core Set data to help develop quality improvement efforts. This year, we've asked the workgroup to think about both general gaps as well as patient and family experiences of care that are unique to health home enrollees. For example, which features of the health home enrollee patient experience would be important to capture in an experience of care measure? We are not asking you to identify a particular measure, rather we want to discuss the concept and areas of potential that could help inform the 2029 Public Call for Measures.

We would like to hear from all workgroup members about the gap areas, so we do plan to do a lightning round with workgroup members. We will use the roster for the roll call. We will use the order that we did the roll call in and ask each workgroup member to mention features of the health home enrollee patient experience that would be important to capture in an experience of care measure or another priority gap area. We know this is going to be challenging, but please be succinct and concrete. So let's start the lightning round by hearing from our co-chairs and I will start with Jeannie.

### **Jeannie Wigglesworth**

Hi there. So we end up doing focus groups with the members and the staff every couple of years, but one thing we did this year that was a little different is we focused on social isolation and loneliness because of COVID and how the comeback was a little bit weak. And it was really quite amazing, some of the feedback we got in those focus groups and how important that piece is to recovery.

If you do some research on it, it's almost like a third up here to, you know, mental and medical health. So that to me would be interesting. We probably don't have any measure like that today, but, but something that could, you know, assess someone's social connectedness or the social connection, loneliness. The idea loneliness is more of a clinical theory, clinical issue, but the social connectedness is actually what are they connected, do they have transportation, do they have family, do they have community resources, things like that. If I were to say anything, I would say that because we found it very interesting, the results that we got, and how much our members, this is the SMI population, but how much our members said how important that was in some way or another to them.

### **Emily Costello**

Thanks, Jeannie. Next, we have Kim.

### **Kim Elliott**

I agree with Jeannie, but I would say community integration is probably the biggest thing that is really important from all aspects of what we do from a health home perspective, and making sure that the individuals feel or have the perception that they are able to participate in, whether it's social activities, whether it's maybe church on Sunday or different events that they really want to experience. And then, of course, the resources to be able to make those sorts of things happen for them, whether they're available to them, such as transportation, or maybe somebody to go with them, and those are the experiences I think that are really going to make a difference in quality of life for that individual, so that's what I would say.

### **Emily Costello**

Thank you, Kim. Next, we'll go to Clarissa.

### **Clarissa Barnes**

All right, so my caveat is that I also don't know how this is a measure exactly, but we're just talking high-level theoretical, right? The thing that I've always noticed is the gap generally with quality measures is sort of like, well, where's the patient and their ownership and sort of prioritization of their health metrics and

all of this? And one of the things we're working on is sort of the concept of a patient-directed quality goal where they get sort of, you know, self-rewards for sort of meeting their own measures that we're sort of developing using like RHT funds.

And I don't know exactly where that falls in this, but I just think as we think about sort of connecting, you know, as patients visit different places and we have more technology tools to sort of connect those things between us and different providers and each other, and how do patients access that? It's sort of like, well, how do we continue to empower them to identify things that are important to them and move the needle in a way that's meaningful for people? And I acknowledge that that is a pie-in-the-sky thought in terms of like a standard metric, but I do think it is a gap that I keep in the back of my head as I think about sort of the overall picture.

### **Emily Costello**

Thanks, Clarissa. And yes, we are looking for things that are not necessarily an existing measure, but sort of what an ideal measure could capture. Next, we will go to Jim.

### **Jim Brennan**

Hi. Sorry, I was muted there. I don't really have the program or the operational insight into, you know, what features of patient experience care we would potentially measure. I guess what I would like to add is just from a practical standpoint, if you're planning on measuring this somehow through, you know, patient or family provided, you know, survey type information, that it would need to come from a, you know, a standard survey that's already in place. So we use the NCIAD survey here for home and community-based services experience of care measurement. There's another one for our CCBHC program that's a, I think, a youth experience of care survey.

So I guess my point is that as long as we're not adding another survey to the mix, because it's already challenging to collect that information consistently from different patient groups, then, I mean, from a practical standpoint, that's what I would encourage. That, you know, this should come from a CAPS survey or, you know, or a survey that we're already using in the field. And there's really little opportunity, I would say here, at least in Rhode Island, to add another one to the mix. So that's my two cents.

### **Emily Costello**

Thank you, Jim, for those insights. Next, we'll go to Ari.

### **Ari Hauser**

Hi, Ari Hauser. I prepared for this discussion to recommend a measure of diabetes measurement and/or monitoring. But I think I may instead give a second or maybe a third to measuring social isolation. I had to consider that, but it is extremely important. We know that it has big impacts on health and well-being. And I think for the health home population in particular, it is important. So I still think that diabetes management and monitoring is important, but I think my recommendation would be for social isolation.

**Emily Costello**

Thanks, Ari. Next, we have Raina.

**Raina Josberger**

Hi. I think this is such a difficult question, particularly as every state has different types of programs. But I guess I would kind of lean into the social care needs measure. It's a relatively new measure, but I think it could offer some unique insights here to the health home world. So as that measure continues, I encourage just focusing potentially there.

**Emily Costello**

Thank you, Raina. Next, we have Pamela.

**Pamela Lester**

Hello. Thanks for allowing me to provide some feedback. I agree with Jim. In Iowa, we have the CAPS survey. And so a health home member could potentially fall into the adult CAPS survey, the child CAPS survey, or the LTSS CAPS survey. And would we be able to leverage the surveys that we already do to extrapolate or stratify those in a way that there's no duplication or that we're reaching out to the same person to complete more than one survey. But if we do, I think a standardized survey with this population would be good. And I don't really have any thoughts on exactly which questions within those surveys would be most appropriate for this population.

**Emily Costello**

Thank you. Next, we will go to Johnny.

**Johnny Shults**

I don't know that I have too much to add that others have already, you haven't already shared. I think the importance of the socialization measures, but I would add that there's a lot of states -- each state is handling, re-echoing that each state is handling metrics and differently. And just ensuring that we're not complicating this by adding additional work that may not be in alignment with what the overall state goals are doing. Just again, a caution about finding ways to align.

**Emily Costello**

Thank you, Johnny. And let's go to Laura.

**Laura Vegas**

Thank you. Kind of dovetailing on what other members have said. You know, a couple of gaps that I feel like may be in the measure set are the care coordination piece -- is the care coordination piece. And each year I look for measures that meet the requirements for measure submission around care coordination and I haven't really landed on any that I felt like we're getting at what we need to get at. But care coordination is like the linchpin of health homes, the coordination for complex needs, that's, I think, the

key to successful health homes. You know, person centeredness, what's important to the person, as well as, you know, balancing that with the health and wellness needs of the person and the voice of the person. But to Jim and I think Pamela's point, there are experience of care surveys out there. I work with national core indicators on the IDD side.

So what they said kind of made me start thinking, is it an opportunity to use those experience of care surveys and look for stratification opportunities for people who may be also in a health home to get that experience of care? Or would it be adding experience of care surveys to this Core Set? I don't know, but something to think about. And again, we have great measures that tell us about whether the clinical processes or services have occurred. But, you know, what tells us that these pieces work together? And in my mind, the purpose of the health home actually made that meaningful difference in a person's life. So that would be my thoughts about gaps and thank you.

### **Emily Costello**

Thank you, Laura. Now I will provide an opportunity for public comment on the priority gap areas in the Core Set as well as criteria for the Public Call for Measures. If you'd like to comment, please use the raise hand feature at the bottom right section of the panel and we will call on you. Okay. I am not seeing any hands from the members of the public in attendance. I will open it back up to members of the workgroup if there's any follow-ups you'd like to add. And I see Kim, you have your hand up, so go ahead.

### **Kim Elliott**

One of the things that I think is really important to keep in mind, a lot of these individuals really like to have some control over their life, their life experiences, and we don't have measures that really kind of capture that experience as well. I know that the NCI-AD survey does capture it, but may not be ideal for all of the individuals enrolled in health home. CAHPS captures maybe some of those, but things such as controlling when they have their meal, what they have to eat, who they associate with, whether they have access to transportation to do the types of things that they would like to do.

It's basically that whole control and feeling that you have some control over all of the different components within your life. And a lot of that, I think somebody mentioned earlier, care managers can have a great influence on that and making those things more person-centered and making sure the perception of the member is that they do have some control over things in their life. And I think some of the surveys do answer that. Maybe there is a way to stratify some of the measures or the surveys that are already being done to capture this population, but I think that would come down to some changes perhaps in the sample frame and things like that. So I just wanted to bring that up. I think it's really important from a member perspective, putting that member first.

### **Emily Costello**

Thank you, Kim. Any other workgroup members? Anything else to add here? Yes, Jeannie?

## Jeannie Wigglesworth

I would just add really briefly that I'm on the same page as everyone who spoke up about not creating another survey or another assessment. And I can see that firsthand with the providers that it becomes overwhelming. Individual programs sometimes have different types of assessments they have to do on top of the state assessment. So I am 100% for that. And the only idea I could think of is if, you know, wherever who feels the best people are already collecting this data, if we just maybe can require certain requirements to the assessment so that they can implement it in their way, but they're meeting the bar of what we want addressed or reviewed or that type of thing.

## Emily Costello

Thank you, Jeannie. All right. We can move on to the next slide. Okay. That was a great discussion. We've covered a lot of ground today, and we've now come to the reflections part of the meeting. So to begin, we're going to recap the workgroup's recommendations for updating the 2028 Health Home Core Sets. The workgroup considered two measures for addition to the 1945 Health Home Core Set and one measure for addition to the 1945A Health Home Core Set. And as a reminder, to be recommended for addition, a measure required a yes vote from at least two-thirds of the workgroup members, which in this case was six.

We want to thank everyone for managing the voting technology in this virtual environment. Our votes came in very quickly, so that was very nice to see. As a summary, the workgroup did not recommend the adult access to primary -- or adult access to preventative and ambulatory health services to the 2028 1945 Health Home Core Sets. The workgroup also did not recommend the LTSS comprehensive assessment and update MLTSS-1 and LTSS-1 to the 2028 1945 or 1945A Health Home Core Sets. Reflecting on the workgroup discussion, there was considerable discussion around the criteria discussed earlier today, including making sure that the measures were actionable. We heard from representatives from New York and Connecticut talk about how they use the measure to understand and drive care delivery.

There was some conversation around the measure's meaning and if the results are meaningful for states as well as Health Home Programs. We also heard a lot of discussion about how data are collected. We heard that states collect and use data from these measures in a variety of different ways and it's important for workgroup members to understand how they might collect the data. We also heard some great exchanges between states and an opportunity to learn from one another as part of our measure conversation. Next slide, please.

Now we would like to provide the workgroup members with an opportunity to reflect on the 2028 Health Home Core Set Annual Review as well as think about future directions. We have two questions listed here on the slide to guide your reflections. So the first is, in thinking about the 2028 Medicaid Health Home Core Sets, what technical assistance could support future state reporting? And the second is, based on the gaps discussion, are there additional needs to support the identification of measures to fill gaps in the Medicaid Health Home Core Sets? Specifically, we have a follow-up question about the use of technology and ECDS to support ease in data collecting and reporting, which aligns with some of our conversations earlier today. We will not be doing this round robin style, so anyone that wishes to speak can raise their hand and I will call on you. All right, Clarissa, thank you for kicking us off.

**Clarissa Barnes**

So I think that it's sort of a slightly aside related to the technical assistance related to the future state reporting. I guess my question or statement to reflect what some of myself and others in this group have talked about in terms of like not wanting to overwhelm people with new measures, wanting to make sure that we're not trying to sort of overburden with additional measures and looking at state alignment, like at what point is there assistance or connection with sort of like the general trend?

I mean, I know that not every state has signed sort of the quality pledge with regards to sort of state measure sort of alignment, but like do those work sort of intersect at some point to make sure that we all are moving in the same direction when it comes to sort of alignment of the way that we're thinking about quality measures and we're not sort of creating these in a, you know, separate space without thinking about the larger quality context? Does that make sense?

**Emily Costello**

Yes. Okay, Jeannie, go ahead.

**Jeannie Wigglesworth**

So I don't know. This is kind of a different type of suggestion, but it would be interesting to have maybe a subcommittee here to discuss the barriers and future plans of getting supplemental data and how states are struggling or what's working or what systems are better than others or, you know, not necessarily so formal about certain measures, but just, you know, a support group basically on how people are moving toward e-measures and supplemental data, I think will be beneficial. I know we all have too many meetings, but it really is great to hear from other states and what they're doing. And you just learn so much.

So I think it was really worth it personally. And for the gaps in care, again, I agree not too many, not adding new assessments, but figuring out what providers or states are already doing and making sure that they're meeting certain criteria of addressing certain topics that we feel is important. That's all I got.

**Emily Costello**

Thanks, Jeannie. Kim?

**Kim Elliott**

So many health plans, whether they're physical health, dental health, behavior health, have gotten really, really good at electronic capture of information, whether it be from medical records or, you know, other data sources like data aggregators. And if there's a way that there could be some technical assistance around maybe capturing some of those methods that health plans are so successful with for supplemental data for measure reporting and how that might also apply maybe from a state perspective, maybe there's some way to capitalize on that.

And then from a gaps discussion, I think we're still not as focused on the outcomes as we are on some of the more processed measures. So just thinking through some of the things that we think and have talked

about that are really important and how if there's an easier way to capture that data and more focus, I guess, on the outcomes versus the process part of it.

## Emily Costello

Thank you, Kim. Any other comments from workgroup members? All right. I'm not seeing any more hands. We can go to the next slide. Now we would like to provide one last opportunity for public comment. Again, if you'd like to make a comment, please use the raise hand feature at the bottom right of the participant panel to join the queue and lower your hand when you're done. And we will let you know when you are able to unmute. All right. I'm not seeing any hands. So we will move on to the next slide. As we wrap up, I would like to outline the next steps.

So our next step will be to review and synthesize today's discussion and we will prepare a draft report. We anticipate making the draft report available for public comment in November. Workgroup members, as well as members of the public, will have an opportunity to review and comment on the report. We expect to release the final report in February 2027.

From there, CMS will obtain additional input as needed from interested parties, including other federal agencies, and we'll make the final determination for the 2028 Medicaid Health Home Core Sets. If anyone has any questions for our team about the content of this meeting or the annual review process, please email us at the email address shown on this slide here. Next slide. And finally, one last thank you to all of our workgroup members, federal liaisons, measure stewards, and public attendees for your contributions.

We want to express our appreciation to the staff of the Medicaid Benefits and Health Programs Group and the Division of Quality and Health Outcomes at CMCS for your support. And a special shout out to the Medicaid Health Home Core Sets team. This meeting would not have been possible without everyone's help. We wish everyone well. This concludes the 2028 Medicaid Health Home Core Sets Annual Review Workgroup Meeting. The meeting is now adjourned.