Medicaid Health Home Core Set Stakeholder Workgroup:
2022 Annual Review Voting Meeting Transcript
Day 2: August 18, 2021, 11:00 am – 3:15 PM ET

Good morning, everyone, and welcome to Day Two of the 2022 Medicaid Health Home Core Set Stakeholder Workgroup Voting Meeting. This is Patricia Rowan again, at Mathematica. Before we get started, I just want to revisit our housekeeping items, and I would also encourage the Workgroup members to make sure you are logged into the voting platform this morning while we wait.

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All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for Workgroup members and the public to make comments. To make a comment, please use the raise hand feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. Those who have joined us today using the mobile app will need to open the participant panel by tapping on the participant icon, and the raise hand icon will appear at the bottom of your screen. Folks will be unmuted in the order in which your hand was raised, and please wait for your cue to speak. Remember to lower your hand after you have finished speaking, and the way you do that is the exact same way you raised it, so just click on that again, and there should be an option to lower your hand.

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If you have any technical issues during today's webinar, please send the event producer a message through the Q&A function. Please note that the chat function is not enabled during this webinar, so you will need to use Q&A to ask for support. If the host has unmuted your line during the public comment period and the audience is unable to hear you, please ensure you are not muted locally on your headset or phone. If the issue persists, we recommend reconnecting your audio using the call-me feature in audio settings. Audio settings can be accessed by clicking the arrow next to the mute button on the button of your screen. Please note that call-in only users cannot make comments. To make sure your audio is associated with your name in the WebEx platform, look for the headset or phone icon next to your name in the attendee list.

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Before we get started, I wanted to recap the highlights from yesterday's meeting. We kicked off our time together by revisiting the context for this annual review process, including the measures currently in the Health Home Core Set and the measures that were suggested for addition or removal. Then we turned to discussion of measures that were suggested for removal. The Workgroup discussed three measures that were suggested for removal, and two of these measures were recommended by a two-thirds vote of the Workgroup for removal from the 2022 Health Home Core Set. These measures that were recommended are Initiation and Engagement of Alcohol and Other

Drug Abuse or Dependence Treatment and Screening for Depression and Follow-up Plan. After the removals, we turned our attention to discussing the first two measures that were suggested for addition, and those were Follow-up After Emergency Department Visit for Mental Illness and Asthma Medication Ratio. One of these measures was recommended by a two-thirds vote of the Workgroup for addition to the 2022 Health Home Core Set, and that was the Follow-up After Emergency Department Visit for Mental Illness measure.

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So now let's move into a Workgroup roll call. Next slide.

As I go through the roll call, I'd like to ask that Workgroup members raise their hands when their name is called, and we'll unmute you, and you can say hello. Please remember to then mute yourself in the platform and lower your hand. This will allow you to mute and unmute yourself whenever you'd like to speak during the measure discussion. If you leave and re-enter the platform or find you've been muted by the host due to background noise, just raise your hand, and we will unmute you.

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On this slide, we have listed the Workgroup members in alphabetical order by last name. Let's start with Fran.

Hey. Good morning, everybody. Fran Jensen from Maine Office of MaineCare Services.

Thanks, Fran.

Kim Elliott.

Kim Elliott with Health Services Advisory Group. Welcome, everyone.

David Basel.

Avera Medical Group, Basel. Thanks.

Dee Brown.

Hi. This is Dee Brown from UnitedHealthcare. I'm the National VP for Community Integrated Care for United.

James Bush.

Howdy from Wyoming. I am the State Medicaid Medical Director.

Karolina Craft.

Hi. Good morning. Karolina Craft from Minnesota Department of Human Services.

Samantha, are you on the line? Okay. Maybe Samantha is not here with us yet. Pamela.

Hi. I'm Pamela Lester from Iowa Medicaid.

Libby Nichols.

Hi. Libby Nichols from New York State Department of Health.

Linette Scott.

Hi. Linette Scott from the California Department of Health Care Services, Chief Data Officer.

Do we have Jon Villasurda? Jon, are you here? I don't see Jon. Okay. Theresa.

Hi. Theresa Walske, Wisconsin Medicaid.

Okay, and we heard from Roderick that he will not be joining today either. Okay.

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We're also joined today by federal liaisons who are nonvoting members of the Workgroup. I will read the names of the agencies represented but not do an individual roll call, so we have the Administration for Children and Families, the Administration for Community Living, the Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality at CMS, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration. Federal liaisons, if you have questions or contributions during the Workgroup discussion, please raise your hand, and we will unmute you to join the discussion.

Next slide.

So, we will kick off today's meeting by discussing the remaining measures suggested for addition, but before we do that, I would like to give our Workgroup co-chairs, Fran and Kim, an opportunity to share some welcome remarks, so I think we said, Kim, you would go first today.

Yes, and good morning, everyone, and welcome. I think we had a very good discussion yesterday on each of the measures that we were reviewing, and what I particularly enjoyed and thought was productive was all of the varying thoughts and opinions from our backgrounds and our experience working in the field, working in the programs and, of course, perhaps with these direct measures, and I think if we continue to apply those concepts today and really think about how the measures that we're reviewing or considering will impact from a health home perspective versus a general Medicaid or any population, I think that that will serve us very well as we proceed through our work today. So I'm very excited to work with all of you again today and look forward to a very productive discussion.

Thanks, Kim. Fran.

Good morning again, everyone. Thank you for your participation and sharing some reflections from yesterday. Again, echoing what Kim said, I thought it was a really great discussion. I was talking to a friend about it last night and said how impressed I was with everybody getting everybody's different opinions across the country, which I think is super important and reflects not only the importance of this work but also the complexity. I'm sort of thinking today about importance of using measures as quality improvement, not as a particular judgment for pay-for-performance although we could maybe get to that at some point assuming the measures are okay but also reflecting on how always the tension between sort of quality improvement within a population versus quality improvement for an individual patient or member and their medical team. So again, look forward to the discussion and looking forward to hearing from you all. Thank you.

Thank you, Kim and Fran. So now we will turn our discussion to the remaining measures that were suggested for addition.

Next slide.

Patricia.

We will start --

Patricia, I'm sorry to interrupt, but can we try to figure out about Sam being able to unmute? We might need -- I'm sorry, everyone. We might need to do a little bit of troubleshooting.

Yeah, so, Derek, is there -- We do have Samantha. She told us she was dialed in. Is there anything we can do to unmute her?

Your line is unmuted. Are you able -- Is this Sam?

Hi. This is Samantha Ferencik from Kansas. I hope you all can hear me.

Yes, we can. Hooray. Thank you so much, and thanks, Derek and Samantha, for working through that. Okay. Why don't we go to the next slide? And we'll proceed with the discussion. Samantha, just as an FYI you probably will not have the raise hand feature, but feel free to either let us know in the Q&A if you want to make a comment, or you can just unmute yourself and join the discussion.

All right. So we will begin this morning by discussing the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control measure. This measure is the percentage of beneficiaries ages 18 to 75 with diabetes type 1 and type 2 who have hemoglobin A1c in poor control, greater than nine percent during the measurement year. The measure steward is NCQA, and it is NQF-endorsed. The measure uses the administrative, hybrid or electronic health records data-collection method, and the measure is currently on the Adult Core Set. This slide also contains information about the denominator and numerator statement for this measure.

Next slide.

The next measure suggested for addition that we'll be discussing this morning is Colorectal Cancer Screening. This measures the percentage of patients 50 to 75 years of age who had appropriate screening for colorectal cancer. The measure steward is NCQA, and it is NQF-endorsed. The measure uses the administrative, hybrid and the Electronic Clinical Data Systems, or ECDS, data-collection method. This measure has been recommended for addition to the 2022 Adult Core Set.

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This slide contains information about the screenings for colorectal cancer that are included in the measure's numerator.

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So now we will open it up to Workgroup discussion about these two measures that were suggested for addition. As we did yesterday, we'll take each measure in turn, so let's start with Workgroup discussion about the Comprehensive Diabetes Care measure. Again, Workgroup members, please raise your hand. We'll call on you, and then you should be able to unmute your line if you wish to speak. And I see Jim Bush has your hand up. Go ahead, Jim.

Thank you. Yeah. Diabetes is always near and dear to my heart. I had a question and a thought on this one. So, my question is, I was noticing that you can say one of the exclusions is age 66 and older with frailty and advanced illness as an optional exclusion, and I think operationally if someone was wanting to game the system, you know, how are we defining that? Do we have a severity-of-illness score? I didn't see it in the material you gave us for review.

So that's my first question is that, as it says, you know, "18 to 75 unless you're 66 with frailty," whatever that means, and the second thing is, I think, for medical health home, this is fine because I think they should know the A1c. I think just in generally I don't like chart-review-type records, and I don't like Core Set measures this like this because they're administratively very difficult for, like, a full Medicaid program, but I think in this narrow-defined health home population, I think it's good. I think once we get really connected to HIEs, measures like this are going to become a lot more feasible. So that's my question and my comment.

Thank you, Jim. To your question about the measure specifications and exclusion, I'm wondering if there's anyone from NCQA on the phone who could speak to that. Please raise your hand, and we will unmute you. I see Lezley Brown or Alyssa Hart from NCQA. Any chance that either of you could speak to this question? Emily Hubbard, also from NCQA, please raise your hand or let us know on the Q&A if you're here, and we can unmute you to answer Jim's question. Okay. We will keep trying, Jim, to connect with someone from NCQA to answer that question about the exclusion. In the meantime, why don't we go to Dave Basel if you want to go next?

Yeah, thanks, so I kind of alluded to this yesterday in some of the opening comments. So from a clinical standpoint, when I'm looking at performance improvement at a health system or clinic level, this is probably the most important metric that I look at because of the prevalence of diabetes, its effect on morbidity, mortality, and cost, and so similar to the last speaker, this is near and dear to my heart. Now, that being said, in this context, when you move into a blend of administrative claims and EHR type of stuff, that just muddies the water so much that you're really measuring here, in this context, you're actually measuring all of the health home data systems or the state programs' data systems rather than the clinical thing that you're trying to measure, and that makes performance improvement really difficult, and so I think until -- I think this is, you know, a couple years ahead of its time. You're going to have to wait until you get true interoperability to the HIEs, the last speakers, to protocol, bringing it across automatically so you can get that data reliably. Otherwise, you're just comparing apples and oranges between every individual clinic and every individual state, and that makes it really hard and not that useful of a measure to look at, at this time in my opinion.

Thanks, Dave. Margo, I think, can speak to Jim's question about the exclusion, so let me go to Jim, or let me go to Margo, and then we'll go to Dee.

Sure. Thanks, Tricia. And I don't pretend to speak on behalf of NCQA here, but I am reviewing the technical specifications. This is not an uncommon optional exclusion within HEDIS measures, and there are value sets, Jim, that include codes that would be used, so I'm sure you know the value sets get brought into a programming specification with specific codes for frailty device value set, frailty diagnosis value set, frailty encounter value set, and frailty symptom value set, and there are various other codes related to advanced illness and so on. So the codes are all specified. They're all available within the value sets associated with the Core Sets and can be called into the various specifications, so it's not a specific score or anything like that. It's all based on diagnoses or encounter values that would be included within the technical specifications, and we can send you the link to the technical specifications if you want to look at them more closely, but I think that goes back to the point that David was making about the data in the data system, that the data have to be there to be able to call this in as an optional exclusion.

Thanks, Margo. Dee, you have your hand up. Go ahead.

Yes, thank you. So multiple states have chronic condition health homes that are managed, not in a medical home environment, not in a PCP environment, but by community-based organizations, and the CBOs who are providing care management do not have access to lab results and an HIE typically, and even if they did, the measurement is not readily available to the frontline case manager, and as we all recognize, case managers are not diagnosticians, so I just really do believe that this is not applicable to this program from a programmatic standpoint because care managers have very little influence over a member's diabetic control other than talking to the member about how to manage their chronic illness, and we do have information that care managers encourage members to get exercise, encourage members to go see their PCP and get their labs tested, talk to their primary care physician about appropriate weight loss, healthy eating, all of those things that are attributable to helping members with diabetes, but a care manager cannot diagnose the diabetes, nor can they get access to the lab results in looking at an A1c that's under poor control. So for those reasons, I don't believe that this is an applicable measure for the health home program.

Thank you, Dee. I see Pam's hand and then Fran, so let's start with Pam.

Thanks. I really like this measure. For our performance measures, our VMCOs actually measure the components of diabetes less than eight, which is essentially, you know, pretty close to the same thing. We also, in both -- I really think that this is great across health home populations as there are certain medications that the folks in the behavioral health health home can cause weight gain and subsequently diabetes, so I think that this applies to not only the chronic condition but the integrated programs. So the thought that it hits multiple health home types, I think, makes this a valuable measure to have as part of the Core Set.

Thanks, Pam. Fran, you're next.

Yeah, I was going to ask a question about what folks have heard from their health home partners about how difficult it is to get this measure. To your point about EHRs not being accessible to all those who have to report on them, I think it speaks to what the previous speaker said about a lot of them are CBOs. I also have just some challenges with looking at greater than nine. It's really indicating that 8.5 is good enough, or 8.9 is good enough, and hemoglobin A1c is really just a clinical marker of what the diabetes control for hyperglycemia is in this case, not necessarily hypoglycemia, which is a very feared complication of particularly folks who have diabetes, and it also doesn't really reflect patient centeredness. Sometimes, patients don't -- if they're on multiple medications or have other things going on in their life, they can't just focus on their diabetes, and actually the studies have shown that controlling other risk factors are more important for preventing macro and microvascular disease.

So, I think obviously diabetic control is extremely important, but whether this is a good example of, or a good indication of that from a clinical perspective is something we don't need to debate here, but also, from the health home perspective, is this, to your point about -- is it something a care manager has access to given the state of the data systems? It just makes me worried to teach to a test. That's my bigger point. Okay. I'll shut up now.

Thanks for those comments, Fran. Kim, I see your hand raised. Go ahead.

Yeah, thank you. I always do struggle with how we -- the type of measures we should select for the Core Sets, but one of the things that I'd really like to shift, but because of wanting to align with other Core Sets, I understand why we want the poor control. I think, from a public-facing and positive direction, I'd rather see measures that are in control being reported, but with that said, I think we do have to include measures such as this one so that we can really show the -- it's not really the outcome, but it's the indicator of the outcome of all of the work that's being done in the health home for people with chronic conditions, so I really do think it's a good measure to include and an important measure to include because it is one of the most prominent or prevalent diagnoses that people encounter in a health home environment.

Thanks, Kim. Linette, you were next.

I would just echo what, in a sense, what's already been said, agree with the importance of the measure but also just to really emphasize the challenge of collecting the data and collecting the data in a consistent way. We've been looking at how to use the claims data, but the codes that are necessary to get it from claims data are not routinely reported, and so it then requires chart review or EHRs, and so, again, it will be easier to look at this measure in the future, and we definitely have it on our aspirational, but unfortunately it tends to go to chart review, and because of the so many different ways to collect it, it just is a tough measure. So, again, doesn't diminish the importance and agree with doing that, but in terms of having it be a measure that gets reported and compared across programs, it is a challenging measure.

Thanks, Linette. Dee?

Thanks. I also wanted to just add that I think it's important that we not ask a provider to perform, that we're going to measure something that they cannot control. So while health promotion is one of the things that health homes provide, and I talked about that previously, about exercise, getting with your primary care physician, asking about your -- you know, understanding your disease state and being able to do the things that might promote better health, especially related to diabetes because that is an important component in a health home diagnostic way. The providers, if they can't impact that other than through health promotion, I think holding them accountable for something they don't have a lot of control over, again, as well as being able to impact the data and know what that data is saying so they know when to act, I think it's not actionable on a provider's end because they don't have that data readily available to them, so for those reasons, I just wanted to comment again about, if we're going to put a quality measure associated to a provider program, the provider should have the ability to control how that measure's outcome is going to be impacted. And I see their health promotion is one way that they can impact it, but if they don't know when to take action other than, this is the reason the person came is because they're diabetic. Therefore, I'm going to go to my playbook for diabetes. What am I going to do for a member who has diabetes? But I'm not going to be looking at whether they're in poor control, good control, or not, because that is not available to me.

Thank you, Dee. Kim, I see your hand is still up. Did you have something else to add on this one?

No, sorry. I'll lower it.

Okay. Just as a reminder, we will have public comment after the Workgroup discussion, so I see a few folks from the public have raised their hands. We will call on you when we get to the public comment period of our discussion. I don't see any other Workgroup members or federal liaisons with their hands up, so why don't we turn now to the Colorectal Cancer Screening measure and Workgroup discussion on that? Theresa, go ahead.

Thank you. I was hoping someone could just explain what the process is. I see the CDC has recommended a lower age group or has reduced the lower age in this measure. I'm wondering, so if this measure is updated -- if we say yes to this measure, do we use the age group that's here, or if by 2022 there's a different age group, how does the measure get updated?

Yeah, thanks for that question, Theresa. Anyone from NCQA able to answer that question, please either raise your hand, and we'll unmute you, or let us know in the Q&A.

Hello, this is Margo. Oh, there's Alyssa. Okay.

Derek, can we unmute Alyssa? Go ahead.

Hi, this is Alyssa. Can you hear me?

Yeah, we can.

Great. We are trying to get the measure champion on the phone, and I have the question written down, but I'm going to reach out really quickly, and hopefully we can circle back to that question, but the question is just about how we define the age range for the colorectal cancer measure, correct?

Alyssa, this is Margo. It's also about guidance given that CDC has changed. My understanding is that that is that NCQA is looking at looking to align, but that that change has not been --

Right, okay. I'm going to reach out to the measure champ and hopefully get an introduction. I'll either put it through the chat or raise my hand again.

Thanks, Alyssa.

Yep.

All right. Linette, I see you have your hand raised. Go ahead.

Hi. I would just speak in support of adding this measure since it's a broad screening measure and has a straightforward way of collecting from the claims data. Also, it was proposed for being added to the Core Set measure by the Core Set measure Workgroup in terms of the Adult Core Set, so it creates alignment there. Yeah, so that's it. Thanks.

Thanks, Linette. Any other Workgroup members or federal liaisons who'd like to comment or ask a question about Colorectal Cancer Screening? Dee, go ahead.

So, I know earlier on our discussion, we had some discussion about reducing health disparities, and I do think the prevalence for colorectal cancer does impact where we have racial disparities, and I think that that's an important factor for that. But at the same time, I don't know if this measure can be influenced by a care manager other than them questioning whether the member has been screened because they're not the ones, but they could facilitate it, so I'm kind of torn because I am very concerned about the prevalence of colorectal cancer in health equity and how we approach it, so that's my comment on this measure set. It's not part of the Adult or Child Core Sets, correct? That's a question.

It is not currently part of the Adult Core Set, but it was recommended for addition to the 2022 Adult Core Set.

Adult Core Set, so there is some alignment there. Thank you for answering that.

Sure. Fran, I see you have your hand up. Go ahead.

I was just going to echo what Dee said. There's really strong data about the lack of screening in BIPOC populations as well as they're at higher risk for colorectal cancer. It's usually presenting later in a later stage, and so, you know, given it's an A and a B, under USPSTF, I mean, US Preventive Task Force, I think a care manager actually can make a huge impact in terms of arranging, you know, reinforcing the importance, of, you know, the prep, getting people help with their prep and doing that education really very focused for the populations that need it, so I love this measure.

Thanks, Fran. Jim, you were next.

Yeah, again, just more of a comment. From our experience with Medicaid, anytime we have an age range this broad, and I love the measure, so don't get me wrong there, but the administrative gets a lot more challenging because, you know, we get Medicaid claims, but then we don't see the Medicare claims because being Preventive Service Task Force, you know, preventive guideline, you know, we don't get cross-over, so it's just a little bit of an administrative hassle, and again, I just urge every time you all talk to CMS if we can find some better way to get better coordination of data between Medicare claims and Medicaid claims, it would make life a lot easier as we go forward with quality, so that's my rant. I think you've heard it before.

Thank you, Jim. I see a lot of Workgroup hands raised, but I see Alyssa from NCQA. It looks like you are in the queue, Alyssa. Did you want to answer the previous question? Or maybe you were just saying you were still reaching out. Derek, can we unmute Alyssa? Is that possible?

Hi, this is Alyssa Hart again from NCQA. We are aware of the updated age requirement, but the change didn't make it into HEDIS measurement year 2022 approved changes. So the earliest that that change would be reflected is the HEDIS technical update for measurement year 2022, and we do have an FAQ on this issue with more information, and I can put the link in the chat to the larger group if that works.

Yeah, if you could send our team the link, we can share it. That's helpful.

Okay, great. Yep, I just sent that.

We don't have chat enabled. Not everybody will be able to see it. Thank you.

Got you, yep.

Okay, Pamela, you were next. Go ahead.

Yeah, thank you. I think I really like this measure. I'm really excited that this measure was suggested, and there's several reasons. One, you know, the health home program is meant to provide whole-person care, so whether you're in the behavioral health, the substance use, the chronic condition, the HIV/AIDS, whatever it is, we should be providing whole-person care and working with providers that that member is seeing and coordinating all of their care. So it's important that we get this information and sometimes from a policy standpoint putting things in place so that it kind of drives that, you know, importance of providing whole-person care and coordinating with those providers.

One of the other things I like about this is NCQA is working on this measure to be able to, and they might be able to speak to it better than I am because I am not an NCQA expert by any means, but being able to look at disparities in care with this measure is -- I believe is it 10 measures or is it five this year? I'd have to look back at my notes. So there's some really great things going on with this measure in addition to being potentially part of the Adult Core Set. So I really like that, and I think it's really important as we begin to look at within our populations, and I believe that health homes really should be looking at health inequities within our populations and identifying those services that our members need or are most highly needed, so I just am really excited and thankful that this measure was suggested.

Thanks, Pamela. Dave, you were next. Go ahead.

So very similar comment to the last metric, this is one of my favorite and I think most impactful clear-cut metrics when I'm dealing with health systems and clinics and internally looking at EHR data, and we've made great strides on this metric. However, when you're looking at it in this context and you're looking at the HEDIS claims-based metric or a hybrid metric, I found much, much less value in this with other payers.

So, you know, the claims data is pretty well worthless because none of it ever goes back 10 years, and so it's not useful for a care manager to look at the claims data at all because it's always incomplete, and then when you start adding in a hybrid EHR type of metric, then you’ve stopped measuring the clinical performance, and you started measuring the data capabilities of whatever group you're dealing with, whether that's from a policy standpoint and you're comparing different health homes to each other, you're actually comparing their data capabilities, not their ability to screen for colon cancer. So similar to the last one, this is 2 or 3 years too early in my opinion for this measure. Until we have more true data interoperability, you're not measuring what you think you're measuring with this measure.

Thanks, Dave. Kim, you were next, and then after Kim, we'll go to Karolina. Kim, you may be muted.

You're correct. I was. I do like this measure as a measure for the Core Set for health home. I think health home is really an ideal place to really drive improvement in a rate that is so critical for the population. I think that because of the relationship building and the trust that is built in a health home environment that it really creates that much better opportunity to really have an improved outcome for individuals and improved rates for this particular measure, so I do support this measure.

Thank you, Kim. Karolina.

Yes, thank you. I also like this measure. I've been using it for a couple of years and recommended it for various programs, but I do always get a pushback from providers in terms of calculating this measure from claims because, you know, it looks back 9 years prior to the measurement year, and as previous speaker was saying, you know, that obviously is very difficult with the Medicaid population, so I think I have two questions. One is, is anyone else also hearing this pushback from providers about using this measure? And the second question is for NCQA. In previous years, this measure was not in the Medicaid product line, and I was just wondering if it is now.

Thank you for those questions, Karolina. Why don't we take the first part and see if any other Workgroup members want to speak to pushback, and then I will go to Alyssa for the question about whether it's in the Medicaid business. Any other Workgroup members want to respond to Karolina's question about provider feedback on this measure? Dee, go ahead.

I would agree that it's going to be difficult for us to expect any of our providers to know on a member who's on Medicaid for 9 years whether or not they had this unless they have a personal health record for the member, so for that reason, I do understand the difficulty in collecting, but I also, again, do support this measure because I'm glad it was recommended because of the health disparity issue. I think there's a lot of support that care managers can do. The capturing of the data I think I would like the states and CMS to weigh in because as other speakers have offered, we have many duals that are in our health home programs, and not having the Medicare which is primary payer data information and sharing the data, I think there is a data collection component here that we have to consider is going to be very difficult, and not even an MCO might have both.

Until the Medicare-Medicaid alignment models that are occurring slowly in each market, it will be difficult for even an MCO to capture this data and know that it's impacting their members who are in a health home and share that data with a health home. All the way around I do understand the difficulty in the data capture, but I also really like this measure because I think there's a lot of influences other speakers have noted that can really influence a member of getting this service, talking about the importance of it and talking about the trusted relationship between the care manager, so for that reason, I do really like it, but I am very cognizant of the difficulty in data. I have not heard this from any of the provider practices in the states that I oversee only because it's not a required measure set today.

Thank you, Dee. Alyssa, can we unmute Alyssa in case you can answer the question about whether the measure is specified for Medicaid?

Hi, everyone. This is Alyssa from NCQA again. The measure is currently not specified for Medicaid. In HEDIS in Measurement Year 2022, it is currently only specified for the Commercial and Medicare product lines, but it is something we're looking to expand into. We're looking to expand into the Medicaid product line as well, so that would be coming up in future years if approved.

Thanks, Alyssa.

Sure.

Any other Workgroup member comments on the Colorectal Cancer Screening measure? Fran, go ahead.

Yeah, the issue of Medicare and Medicaid claims, I was wondering if CMS or we could get follow-up on this would be how does the duals office and specifically the SDRC, the Integrated Care Workgroup that Mathematica helps to support could help with that data? It's a little bit of an off topic, but that could be an area of internal improvement to help with that, and maybe that would help allay some folks' concerns knowing that there is technical assistance out there. It's not an advertisement, just a thought for how we could improve.

Fran, that's a great point. Thank you for raising that. I think as a result of some of the convenience we've had, we have put states in touch with the State Data Resource Center, I think is what it's called, and so I think it's something we definitely want people to be aware of particularly as we move forward in the future of trying to be more inclusive of dual eligibles in the Core Set, so thank you for raising that. I also wanted to see if there was anybody on the Workgroup that wanted to respond about the 10-year look back. Linette, I think this is something that you have talked about in the past. I don't know if you have anything that you can add to that. I think what we heard in the Adult Core Set conversation about this measure is that the data currently in the systems have sufficient capacity for reliably capturing this information, but I would be interested in hearing if there is -- because it's certainly something that we've been concerned about, the reliability of the measure, the capture of the data for 10 years, so happy to have someone who is more experienced with this measure speak to that, or, Alyssa, if you can speak to that, that would be great.

Yeah, if anyone wants to respond that, feel free to raise your hand. Dee, go ahead.

I do want to understand the person who was speaking that today, this is not going to be on the Medicaid Core Sets. Even though it was recommended for the Adult Core Set, it won't be on the Medicaid Core Set. Is that accurate understanding?

Thanks, Dee, for raising that question. That is not quite right in the sense that CMS still needs to review the recommendations of the Workgroup and engage with stakeholders, and CMS will be issuing its updated Core Set by December 31. We did talk to NCQA about adapting the measure for the Adult Core Set which is, as you know, in the Medicaid line of business even though it is not currently specified for Medicaid in HEDIS, and I think we have assurance that we could bring that measure into the Adult Core Set without any adaptations. And so there is other work to be done to specify it for HEDIS reporting, but for the purpose of Adult Core Set reporting, we could include it as part of the Adult Core Set, and if Alyssa is there and wants to speak more to that or anyone else from NCQA, please go ahead, but those are the conversations that we've had because we had similar questions about whether it could be brought into the Adult Core Set for 2022.

And the Medicaid Adult Core Set, or that wasn't part of the prior discussions?

Medicaid Adult Core Set, the Adult Core Set applies to the Medicaid population. That's correct.

Okay, thank you

Yes.

Alyssa, I see you have your hand up there. Can we unmute Alyssa?

Hi, everyone. I would just like to echo everything Margo just said; that it is possible if CMS approves the inclusion of the Colorectal Cancer Screening measure for the Adult and Health Home Core Sets that we could work to make the HEDIS specification apply to the Core Sets for federal fiscal year 2022, but if it were to be added to the HEDIS Volume Two as well for the Medicaid product line, that would be a larger item that needs approval and then specification for the HEDIS manual.

Thanks, Alyssa.

Sure.

Other questions or comments about Colorectal Cancer Screening from the Workgroup? All right. Well, seeing none, let's move onto the public comment period and the next slide.

So now we would like to open it up for public comments about either of the two measures that the Workgroup has discussed this morning, the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control measure or the Colorectal Cancer Screening measure. If you would like to make a public comment, please raise your hand, and we will unmute you. Jim, did you have a question while we're waiting for others from the public?

No, no, I was just saying that at the top of the hour, I've got a hard break where I've got to meet with the director again so.

Okay. Yeah, thanks for sharing your votes.

So you got my vote.

Yes, we did. Thank you.

Sorry about that. It's just work.

That's fine. Thanks for letting us know. All right. Anyone else from the public would like to make a comment about these two measures? All right. Seeing none, let's move onto voting on these measures, so I will ask my colleague Erin to pull up voting. Workgroup members, please be sure that you're logged into the voting platform same way you did yesterday. Let us know in the Q&A if you have any issues logging on, and if you cannot log on, please send us your voting preference in the Q&A.

So our first question is, should the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control measure be added to Health Home Core Set? And the response options are, “Yes, I recommended adding this measure to the 2022 Health Home Core Set” or “No, I do not recommend adding this to the 2022 Health Home Core Set”. Voting is now open.

Samantha, if you are on the line, we did not receive your vote. Can you put it in Q&A if you're not able to access the voting platform this morning? Thanks for your patience, everyone. The first vote of the day is always the hardest. Samantha, we are just waiting on your vote. Let us know if you sent it via Q&A. We didn't see it. Make sure you send it to all panelists. Thanks, Samantha. We got it. We will just enter it in the platform.

All right. Now we've got all 11 votes recorded. Let's lock the response and show the responses please. All right. So, for the results, 27 percent of Workgroup members voted yes. That does not meet the threshold for recommendation, so the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control measure is not recommended by the Workgroup for addition to the 2022 Health Home Core Set.

Next question: So our second vote is, should the Colorectal Cancer Screening measure be added to the Health Home Core Set? The options are "yes, I recommend adding this measure to the 2022 Health Home Core Set," or "no, I do not recommend adding this measure to the 2022 Health Home Core Set." Voting is now open.

Libby Nichols, we did not get your vote on this one. If you're having any issues -- Oh, looks like, now, we got it. Now we've got all 11 responses. Let's show the results, please.

All right. Seventy-three percent of Workgroup members voted yes. That does meet the threshold for recommendation, so the Colorectal Cancer Screening measure is recommended by the Workgroup for addition to the 2022 Health Home Core Set. Thanks, everyone, for working out those first two votes of the day. They're always the hardest.

Now let's go into the next two measures that were suggested for addition, and I will turn it to my colleague, Jeral Self, to present on these two measures. Jeral. Jeral, can you hear us?

Yes, can you hear me?

Now we can, yes. Go ahead.

Okay, perfect. Thanks, Tricia. Next slide.

The last two measures suggested for addition are the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, Health Plan Surveys, 5.1H, Child and Adult Medicaid Versions. We'll discuss these measures together but vote on them separately. The Core CAHPS Survey provides information on the experiences of beneficiaries with their health care, or parents' experience with their child's health care. The CAHPS survey gives a general indication of how well the health care system meets beneficiaries needs and expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates.

The measure steward is the Agency for Healthcare Research and Quality, however NCQA is the developer of the survey administration protocol. The survey is NQF-endorsed, and it is part of both the Child and Adult Core Sets. The child version of the survey includes parents and guardians of children ages 0 to 17. The adult version of the survey includes individuals age 18 and older. For both samples, the beneficiary must have been continuously enrolled the last six months of the measurement year and must be enrolled at the time the survey was completed. Both samples should yield at least 411 completed surveys. The core child and adult CAHPS surveys include four global rates reflecting overall experience. These are: rating of all health care, rating of health plan, rating of personal doctor and rating of specialist seen most often.

There are also four composite scores summarizing experiences in key areas, including customer service, getting care quickly, getting needed care, and how well doctors communicate. Item-specific question summary rates are also reported for the individual items in each composite. The Workgroup member who suggested this measure also suggested the Children with Chronic Conditions Supplemental Items and the Coordination of Care Supplemental Items for consideration. The Workgroup won't be voting specifically on these supplemental items, but we would like to hear from Workgroup members on the inclusion of these items as part of the CAHPS survey. More details about these two supplemental items are listed here on this slide.

The Children with Chronic Conditions Supplemental Items include three additional composites that summarize satisfaction with basic components of care essential for successful treatment, management, and support of children with chronic conditions. These include access to specialized services, family-centered care, personal doctor who knows the child, and coordination of care for children with chronic conditions. In addition, summary rates are available for access to prescription medications and family-centered care including getting needed information.

Finally, the Coordination of Care Supplemental Items include questions about experience related to other aspects of care. The Coordination of Care Supplemental Items are available for both the child and adult versions of the survey. As shown on this slide, the items include doctors seemed informed and up to date about care from specialists, doctor had medical records, doctor followed up about blood test and X-ray results, and doctor talked about prescription drugs. Additionally, getting help needed from the doctor's office to manage care among different providers and services is also included in this supplemental item. Now I'll pass it back to Patricia to facilitate Workgroup discussion about the child and CAHPS adult surveys.

Great, thanks, Jeral. We will start with Workgroup comments, so please raise your hand if you'd like to make a comment and we will call on you and you should be able to unmute yourself. Dave, I see your hand up. Go ahead.

So, very supportive of monitoring patient experience, and the CAHPS survey is certainly an appropriate one to do that. My main question is around the sampling aspect of this because it's one thing if you're using the CAHPS survey for all Medicaid enrollees, but these health home participants are a very small subset of that, and so are we proposing that we're going to have a separate sampling specifically for health home enrollees? And if so, you're going to have to basically invite almost every enrollee to do it to get up to that 400-sample size that's going to be needed. Otherwise, your n’s are just going to be too small to be meaningful, so that's my biggest concern with this.

Thanks for that comment. Margo, did you want to respond to that question?

Sure, I can start. I think it's a really good point, and it's something that we've looked into in terms of the number of health home enrollees. So one of the things that we've been thinking about is, unlike other health home measures, that this would be done at the program-level as opposed to the SPA level, so in a state that has multiple SPAs, there would be one survey of health home enrollees, and that, we think, is important from both the point that you're making, in terms of the viability of a sample, but then also from a cost perspective, and then also what's the level at which you want to really understand the member experience. We think that doing it at the health home program level is appropriate, and not at the SPA level specifically, so that is one way that we have thought about the challenges of looking at the sample sizes. We believe that most states have adequate sample sizes to achieve the 411 based on the specifications for a sample of 1,350 adults or 1,650 children, so I think that's something else we have looked at. It's not going to be universal across states, but I think most states will have applicable sample sizes, so that's the thinking that we've been doing, and we'd love to hear from you, David, again, or from others about that because we are definitely interested in thinking more about the statistical process here for sampling.

All right. Next, I saw Dee's hand up. Dee, go ahead.

I would agree with David about the sample size because, unless it's being done and delivered, the CAHPS survey is being done by the state themselves. The MCOs have invested, as you all know, lots of funding to have very sophisticated quality measurement data systems and army of nurses to do chart reviews and getting this subset as a separate sample size required of the MCOs is going to be difficult, and so for that reason the sample size is of concern.

The other thing that I'm concerned about is the fact that it focuses primarily, even when they're talking about care coordination, was the care coordination done by your doctor’s office? So they're not asking anything about care coordination done outside of the physician practice that is treating the member, and it's very related to the physicians and the specialists treating the children, so for the child version, while we have chronic condition changed in these programs, I don't know that CAHPS is the best way to capture this. I don't know an alternative way, but what I've always been concerned about with CAHPS is that embedding appropriate members.

Members who are willing to complete a survey when they are happy with their health care versus those who are unhappy with their health care is a big issue for me. I think many of us know, if we get a survey at home, what are we doing with it? Are we completing it and sending it back because we're good stewards of health care? Perhaps, but the layperson day in and day out will respond to a survey because they're not happy, not because they're well served by the system, and while we all want to hear about that, we're not getting a good sense of those people who are being served well versus those that are not being served well, so for a lot of the reasons here, and also for chronic condition children, if the sample size is less than 100, this measure is not even calculating all of the composite scores, so for those reasons, I think CAHPS is maybe not the best way for us to do this for these programs. I think an alternative method might be something we need to consider in future years.

Thank you, Dee. Karolina, you were next.

I think I will largely echo what Dee and David said already, but I also had -- my first initial reaction is that sampling is going to be a big problem. We would have to oversample this smaller group of health home enrollees. Probably would be still difficult to get to the numbers that are required, even if you look at the program level. Another aspect, another sort of, like, problem and issue with this CAHPS survey, it's going to, like, reverse through all the other measures where we want, you know, measures like Colorectal Cancer Screening to be in Adult Core Set here and want to do this alignment.

I wonder if we should think about it the other way around for the CAHPS survey because the CAHPS survey, you know, it's about 30 or more questions or supplemental questions. It's more than 30 questions, that, you know, we send to folks. You know, we send it to adults, but we also want to send it to kids, I mean, about -- to adults who are responding about their kids, and then this one is a health plan CAHPS survey, but there's also another CAHPS survey that is often being used for, like, clinics or for accountable care organizations, so that another 30 questions, you know? Like, people get a lot of CAHPS surveys, so that's another I think something we should keep it mind, whether we do want to, you know, overburden with this one tool. Perhaps there is a better tool too that would evaluate experience of care, something different than CAHPS.

Thanks, Karolina. Linette, you were next.

I would mostly echo what David and Dee were saying, but the other piece I would just add is that one of my concerns again for this population, which is a relatively small population, is doing a survey and being able to do it given response rates to surveys. So I was just checking our last survey response rate for the CAHPS for California Medicaid, and in 2018 we had response rates around 21 percent. In 2019, we had response rates around 17 percent, so, I mean, kind of echoing Dee's comment in terms of who is it who responds and who is in that 17 percent that is actually responding to the survey, and then what do we understand, it's one of those -- I mean, I know I talked about this about the Adult and Child Core Sets as well, but the surveys are just really hard right now because response rates are so low.

Everybody who runs a survey is dealing with these response rate issues and trying to think about what are the ways to increase response rates, and then also to what extent are the response rates low enough that they're introducing a bias to what we're understanding. So, I mean, from a high level, looking at a health home program level, given this program I think makes sense, but even with that, I guess I would go back to the question of are there enough people enrolled to be able to survey enough people that you can get to a 411 when you only have a 17 percent response rate. So that's my significant concern. Thanks.

Thanks, Linette. Cindy, I see you have your hand up. Go ahead. I feel like we may need to unmute Cindy. Oh, go ahead.

Yes, I just got unmuted. Thank you very much. I really appreciate the comments that everybody has made. I want to make my own disclaimer, which is that I do work for the Agency for Healthcare Research and Quality, however I'm not a member of the CAHPS team. I'm the liaison to this health home measurement group in order to bring perspective around primary care improvement, patient-centered care, and other areas that I have some expertise in. I feel that there is a big gap in the current measurements set, a glaring gap, which is around measuring the patients' experience, and also around measuring the core purpose of this program, which is coordination.

I want to sort of comment on or respond to some of the comments that people made. So one of them was about how the care coordination items focused on care delivered by the doctor and doesn't discuss the care manager, and that is correct, however I'd also like to note that there is a question of whether you needed care coordination from your doctor, and that, to me, would speak to how well they felt that their care was being coordinated otherwise. There also are critical components that, just like we care about Colorectal Cancer Screening, care about for enrollees in the health home program, such as, you know, are -- is somebody looking at all of their medicines across all of their providers and other kind of measures that I think, you know, speak critically to why we have this program.

I want to acknowledge the issues around response rates and burden and length, and they're all legitimate. I think Margo addressed at the beginning the fact that it seems like numbers of enrollees would support getting an adequate sample size, and that, you know, it is very -- response rates are very dependent on your mode of administration, so, you know, coupling these or having one of your modes of administration being telephone might be an important aspect of getting a representative sample. One can also do analyses to see what kind of bias has been introduced, and I think that, you know, the idea that these measures are to indicate a need for quality improvement at the program level, so if you are hearing from your beneficiaries that they're feeling like their care isn't coordinated, that they're not able to get care as quickly as they need and other kinds of measures, that is an important red flag that I would think that you would want to, you know, take those data and think about what kind of program improvements might be able to effect that.

Finally, I just wanted to note that I was on the CMS site around the evaluation of health homes, and that Minnesota actually used CAHPS to evaluate its programs. Iowa used another patient experience measure and had 63 items, so I believe there is an interest in finding out what beneficiaries think about their services, and while I don't say CAHPS is the end-all be-all, you know, some of the criteria for these measures were are they in the Medicaid Core Sets for adults and children. We don't have any other patient experience measures that are going to fit that bill, and to develop a different patient experience measure that has the kind of testing, both, you know, cognitive, psychometric, gets NQF endorsed, et cetera, would take many years, so I just wanted to put those thoughts out there. Thanks very much for the opportunity.

Thanks, Cindy. Kim, I think you had your hand up next. Go ahead.

Yes, I just wanted to say that my only concern really with using the CAHPS survey for the Health Home Core Set is the broadness of it and whether it would really reflect the member experience with the health home program specifically. I think that it may not really give us the results that we really need or the information that we really need from a health home perspective.

Thanks, Kim. Pamela, you had your hand up next. Go ahead.

Yeah, I can speak to the Iowa, so Iowa has what's called IPES, Iowa Patient Experience Survey, and it's specifically for the LTSS population. In our state, the health home program falls underneath of the LTSS. While not all health home members are asked for the survey, only the ICM population, which means those that are receiving the children's mental health waiver or habilitation services our habilitation SPA. I do think that patient experience and the voice of the customer is really important when we're looking at quality, and one of the things I was thinking about as everyone was talking was is there some questions that, no matter what survey you're doing, you'd be able to maybe pull a response to that, and maybe that is a conversation for later when we talk about gaps and kind of the future and what it looks like. I think that that would be a great thing to add to the agenda as far as, if these are not chosen, what could that look like?

Thanks, Pamela. Karolina, you were next.

Yes, thank you. I also wanted to speak a little bit about Minnesota. We do use CAHPS in our Medicaid program, Adult CAHPS and then CG-CAHPS for accountable care organizations, and it is from that experience that I think that health plan CAHPS probably will not be able to capture experience with the health home. The questions on the CAHPS surveys are, you know, asking someone, "In the last 6 months, did you get the care you needed?" I mean, they are very general questions. It probably will be impossible for the person responding to the survey to even associate it with the care they received in in a health home as opposed to any other care that they received. It's just, I agree, extremely important to ask about patient experience of care. We probably just need a little different goal.

Thank you, Karolina. Cindy, did you have another comment or question? Go ahead.

Yes, thank you very much, and, Karolina, I was specifically referencing an evaluation that was conducted on the 2010, 2014 health homes initiative, and it was -- I'm just trying to see the -- I believe it was University of Minnesota that was submitted to the Minnesota Department of Health, so I apologize if I created the impression that you had directly done those CAHPS surveys for this program, but it has been done for this population in Minnesota. I just wanted to make one other note, which is that, you know, there are ways in which CMS can support trying to increase the use of CAHPS measures in particular programs and help states with increasing response rates and that sort of thing, and they are currently doing that with the home and community-based services programs so that they have contracts to give technical assistance, are developing a database for states to be able to put their data in that will eventually serve as a benchmarking database so that there are ways to support states in reporting these measures.

Thank you, Cindy. Ruth, I see -- Ruth from NCQA, I see that you put something in the Q&A about the sample size. Would you mind just sharing that with the group? Derek, if we can unmute Ruth.

Yes, hi, good afternoon. I just wanted to clarify, and also there's some discussion about this, the 411 responses, so we just wanted to provide some clarity. It's not required that the CAHPS survey yield 411 responses. It's our targeted number of responses based on the minimum sample size that we have, but in order to calculate the measure result, there needs to be a 100 responses, but I think, you know, members of the Workgroup are expressing other concerns and the -- with the, you know, whether or not CAHPS is the best tool for measuring this patient experience in the population, so just wanted to provide that point of clarification.

Thank you, Ruth. We appreciate the clarification for sure. Are there other Workgroup members who would like to make a comment? Kim and Linette, I see you both have your hands raised. I'm not sure if that's from earlier or if there was something else you'd like to share. Oh, both your hands went down so I'm assuming it's just from earlier. Any other Workgroup members who would like to make a comment or ask a question about the CAHPS measure? Libby, not to put you on the spot, but I saw you had a hand up earlier and then it went down, and I just want to make sure either your question was addressed or ask whether there was anything you wanted to share.

Yeah, I lowered my hand because I was just going to echo what most other people had said as, and, you know, a discussion about kind of the burden of reporting versus what type of information we really get out of it and sample size concerns, and I think everyone else has addressed those adequately, so I put my hand down.

Thanks, I appreciate you echoing those concerns just so we can get the full experience of what everyone in the Workgroup thinks. All right. Other comments from the Workgroup or federal liaisons before we move to public comments? All right. Karolina, go ahead.

Yes, I'm so sorry to get back to this. Cindy, I do know what -- I think I do know what kind of reviews you're referring to, where the CAHPS survey was used by MDH for health homes. It really used a different infrastructure for surveying providers. Back then, the survey was mandatory by the state legislature, so all providers had to take part in this survey, and I think that's probably what was used in those years, 2010, 2014, but since then, it's not mandatory anymore, and a state Medicaid agency needs to conduct the survey, and that really changed our ability to, you know, sample and create, like, this sample that actually represents Medicaid populations. So just want to circle back to that.

Thank you, Karolina. Dee, did you have a question? Okay.

I do not have a question.

Okay, Alyssa. Yeah, I just saw that Alyssa's hand was up.

Go ahead.

Yeah, that's what my comment was.

Okay. That made it -- That just went down, so I'm assuming, Alyssa, that was from earlier. Okay, any other Workgroup comments or questions? All right. Why don't we move into public comments, and we'd like to provide an opportunity for public comments on the CAHPS measures. If you would like to make a comment, please raise your hand and we will unmute you. Any public comments or other Workgroup comments? All right. I'm not seeing any hands raised, so let's move into the voting on these two measures.

Erin, if you could pull up the voting. Just as a reminder to Workgroup members, we are going to take two votes on the CAHPS surveys. Our first vote will be on the child version, and then we'll vote on the adult version.

So our first question is should the CAHPS Health Plan Survey 5.1H Child Medicaid Version be added to the Health Home Core Set? The options are "yes, I recommend adding this measure to the 2022 Health Home Core Set," or "no, I do not recommend adding this measure to the 2022 Health Home Core Set," and voting is now open.

We have a couple folks who need to vote via email or Q&A, so just give us a minute here, folks, and we will make sure everything gets counted.

All right. We were expecting 11 votes, and we have received them, so voting is now closed. So the results, 100 percent of Workgroup members -- Or, actually, excuse me, zero percent of Workgroup members voted yes, that does not meet the threshold for recommendation. Let repeat myself because I was thrown off. Zero percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The CAHPS Health Plan Survey Child Medicaid Version is not recommended by the Workgroup for addition to the 2022 Health Home Core Set.

Now let's move on to the next question. The next question is should the CAHPS Health Plan Survey 5.1H Adult Medicaid Version be added to the Health Home Core Set? The options are "yes, I recommend adding this measure to the 2022 Health Home Core Set," or "no, I do not recommend adding this measure to the 2022 Health Home Core Set," and voting is now open.

We were expecting 11 votes and we have received the 11 votes, so voting is now closed. For the results, zero percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The CAHPS Health Plan Survey Adult Medicaid Version is not recommended by the Workgroup for addition to the 2022 Health Home Core Set.

All right. Thanks, everyone, for sticking with us. That was our last vote. It concludes our voting on measures suggested for removal and for addition, so thank you for your careful consideration of the measures being discussed. That also brings us to our first break for the day, so let's take a break. We will reconvene at 1:15 p.m. Eastern Time, so that’s a little over 30 minutes from now. Let’s reconvene at 1:15. Thank you, everyone.

Hi, everyone. It is 1:15 here on the East Coast, so we will move along in our agenda. Welcome back. I hope everyone had a nice break. At this point, I am going to turn it over to my colleague, Margo Rosenbach, to take us through a discussion of measured gaps and future directions for the Health Home Core Set. Margo?

Thanks, Tricia. Next slide, please.

So we'd like to start off with a discussion of potential measure gaps in the Health Home Core Set, as Tricia said. Next slide, please.

So this includes a discussion of measures and concepts that were suggested for addition to the Health Home Core Set but that were not reviewed during this meeting, and these are housing status and oral evaluation. We're also interested in Workgroup thoughts on potential gaps related to such things as health disparity, social determinants of health and any other gaps you see. For example, in the previous session, we just heard about experience of care measures being a gap, and the decisive vote down on CAHPS suggest that they will still be a gap. We also heard yesterday, as I recall, about measures related to depression screening and similar topics, so at this point I'd like to open it up to Workgroup members to talk about gaps that they see, so who wants to go first? And please raise your hand if you'd like to speak. Jim, you're first. Jim Bush, did you have a comment? How about Dee Brown?

There we go. Yeah, because when I rejoined, I was muted by you guys. So social determinants of health and trauma-informed care are certainly some things that we have been learning a lot more about, and I think really trying to figure out, you know, they've got some codes now, so you've got codes for three or more ACEs. You've got some codes now for the SDOH, so I think trying to look to find ways to fill those, because I think California and Tennessee's experience show the importance of how that increases medical costs and morbidity, so I do certainly agree with those two.

Thanks, Jim. Dee Brown?

Thank you. Yeah, I agree with Jim, housing status and SDOH are certainly something that we need to focus on because it does lend to health disparities. I think the problem that we have, and maybe we consider how to do this, SDOH, while we have codes, doesn't mean that providers will place those codes because they're not billable. They don't get anything for putting that code on a claim, and therefore it's very, very difficult to get providers who know of these factors to put SDOH issues onto a claim because it doesn't matter if the claim pays or not, they're still going to get paid for their services, right? So I think we need to figure out a way to make the SDOH codes, which include housing status, something that creates an incentive payment for providers for adding that issue to a claim, even if it's a small monetary amount, but today, there aren't a lot of APM strategies because many of the APM strategies that are being used today, either by states or by plans, have to do with the overall quality of care HEDIS measures because that's what the focus of the industry has been, rather than on these key components that we know affect health disparities, and can be facilitated by a health home program.

The other thing is catching the referral progress, and I know California is very focused on this, is getting closed-loop referrals for SDOH and other service components that really are tied to health disparities is a great example of what we can do together collectively to come up with ways to capture this data. I think it's an unproven experiment at this point in time about how well will we capture this data because educating providers to do this work is just really an uphill battle for everybody, I think. But I do agree these are true measure gaps and true impacts to our members, both on reducing health disparities and capturing the data itself, so I think whatever we can do to make that, and, another mention, I know you have ACE down here, and ACE is a great tool set, and the multiple assessments that are done in a health home program I don't think are captured through the data systems to know how many of the members got assessed for what and what were the results of those assessments. I think that would be valuable data to capture, and it's only captured in the clinical chart, so that's another gap is, not just only are we doing the assessments, but are we capturing the data that are the outcomes of those assessments?

Thanks, Dee. Libby Nichols?

Hi, I -- this might be redundant, but, you know, while there certainly are a lot of issues and barriers to overcome when considering social determinants of health and housing status, I do want to emphasize that I think when it comes to health problems, those are areas where care managers are doing a lot of work, and being able to measure and document that is a way to acknowledge and validate that they are doing that work, that, you know, often kind of, in some ways, flies under the radar because we're not measuring it, and so while I think that it's a really tough nut to crack, I think it's worth putting time and effort into understanding and finding solutions for building measures around social determinants of health because I think it's important and so particularly relevant to the health home programs.

Thank you. Fran?

Just a question. While we discuss gaps -- and I agree totally about the housing status, and I'm a particular fan of oral evaluations -- are we also taking into consideration feasibility and the fact that it's tough to collect this data? To Dee's point, like, the codes aren't good, and you don't get paid for it, and, frankly, Medicaid can't pay for housing, so, to some extent, what are we doing about it? Never get a measure unless you're willing to deal with the result, right? So to that end, should we talk about -- or should we make those kinds of considerations from the technology -- like, where is the data going to come from? How are we going to enter the data? How are we going to get it out? Is it EHRs? Is it claims, all of the above? Chart reviews, et cetera.

Fran, that's a great point. So I think we could take this conversation on two levels. One is what's desirable? What do we think would be really helpful to drive improvement, improve quality of care, improve beneficiary experience? So that's kind of the blue-sky thinking about what would we like to have that we don't currently have? And then, you're right, there is the feasibility and the viability perspective of, "Well, if this is what we want, how do we do it?" And so I encourage people to think on both levels, not to be stymied or blocked by the fact that it's not currently feasible. I think, given that this is the first time we've convened this group, this is a wonderful opportunity to be thinking long-term, not be blocked by what we can do today, but be thinking longer-term, and so I think it's a great point, Fran, that we shouldn't be focused only on what can we do today?

I also think, to your point about, for example, housing, Medicaid can't pay, and I also think there could be differences between a state that has fee-for-service and a state that relies on managed care, that there's certain things that managed care programs can do and pay for that might not be feasible in a fee-for-service state, so maybe be recognizing some of those differences as well. I think the other thing I'd love to hear from folks is if there are pilots out there, things that people are trying that might be able to be scaled up or tested more broadly in any of the programs that you're working with, or the plans or provider groups. So, Fran, thank you for kind of sharing that big picture perspective, but I'd love to hear us take this on a lot of different levels. So do you have other thoughts, Fran, at this point?

Well, in the interest of sharing what we're up to, and we are fee-for-service which is a, you know, gift and a curse like most things, but we are putting forth a permanent supportive housing option under health homes that is part of the sort of an enhancement to our current community care teams, which partner with our primary care practices as an option, if the primary care practices want to do it, and they'll get an extra, you know, I don't know how much -- I don't know. We haven't figured out the rates yet, but -- and that's essentially a pilot, though it's an option -- using the word pilot is a little challenging because -- but anyway, we are doing -- we're working on it and we'll see what happens, and there's been a ton of positive input from stakeholders, and a lot of interest in organizations taking this on, so it's exciting, but it's just -- it's not even approved yet.

Thanks, Fran. Theresa?

Oh, thank you for unmuting me. I have two points. The first is that I think that we have an opportunity to use the data, and we've been having lots of good discussion -- to use the data to measure and improve member experience and measure and improve our health home programs so that we serve members the best, but I also think we have an opportunity that, within the last years, the state Medicaid programs have created access plans as requested by CMS, and some of the things, like oral evaluations and access to dental care, has been nationally emphasized difficulties with all Medicaid members having access, and so I think we could also define the intent of the data that we're pulling for the health homes, and we could say we're trying to see if this model will improve those access issues that we know we have nationally, and if it does, then maybe we should try and implement it through other populations. I think we have an opportunity to define the intent of the data for the future, or CMS has the ability to define the intent.

The second thing I'd just like to share is that Wisconsin is unique in that we have an HIV/AIDS health home, and we're partnering with our public health, who has a tandem

HIV/AIDS health unit at the state level, and we are both within the Department of Health, and so we're partnering with our public health counterparts to evaluate the data that we are pulling, and we're needing to see how we can improve health homes because some of our members overlap, and so I think working with your public health is a unique opportunity to also gain additional data and to serve the members of your state. Thank you.

I think the concept of linking up to the access plan is a really interesting one, so that's something we should definitely be thinking about further, thank you. Pamela?

Yeah, in Iowa, this is broader than health home, but one of the things that we're doing is, and it came out of our SIM work, to try to get the MCOs to agree to having similar measures in their health risk assessments, and those health risk assessments that they're required to do on a certain percentage, they have a benchmark for that that they have those measures that are the same to be able to look at social determinants of health from the whole Medicaid population, and then I think from that we'll be able to parse out those that are in a health home for that, and then we also expanded our dental to include kids July 1st, so while we try to ensure that the health homes are assessing that the members had a visit to dentist, that really helps open up access to be able to then meet that gap in care, so it would be interesting to measure to see what that impact has on that. I know I was kind of all over the place. I apologize for that. This is really great stuff, so appreciate the conversation.

Thank you. Jim Bush, do you have another comment?

Yeah, I just wanted to respond to the question about how can we collect ACEs data and SDOH data. Several states do pay and have opened the codes. We're in the process of just finishing our re-procurement of our MMIS, and so we expect to open those codes by October, so the providers will get paid for ACEs screening, and also as part of our enrollment and re-enrollment, we're doing an SDOH screening through our health management side, so it is possible, actually, for Medicaid programs, and we're 100 percent fee-for-service as well, to pay providers to collect this data for us and to do some screening, and I just wanted to share that since there was some concern that we couldn't pay providers for that. So that was what I just wanted to add.

Thanks, Jim, that's really helpful. I'm curious from other states, other perspectives whether that's feasible as well in terms of the ability to collect information using existing codes? Dee, do you have a comment?

I did. So just following up on the prior comment I made, there are a lot of assessments that are done in a health home, and we're not catching that data at a national level, so when we were talking about depression screening, you know, we do a PHQ-9 and a PSC-17 and a CAHPS ADL and a DAS score and an audit score and an ACE score, Fall Risk Assessment, CANS assessments, housing assessments, ACE assessments, BMI assessments. That's all done in many of the health homes that we manage, so I think, when we look at this for the future, maybe we come up with what are the assessments that we want health homes to do collectively across all the SPAs, figure out how do we articulate that in a uniform mechanism. I love the fact, Jim, that your state is considering paying providers. I think that's unique and really a great way to go.

To that end, if we had that, we could have a patient experience in a health home discussion that wouldn't be done by the care manager because they could influence the response rates, but it could be done by the health home administrative arm to conduct a similar patient experience measure that we would all say articulates exactly the care coordination somebody gets in a health home. I think that, if we focused on what the assessment outcomes are and then what actions are taken as relative to that, because that -- right now, in a health home, they do the assessments, then they create a health action plan with short-term goals and long-term goals and we figure out how many of the members complete those goals over time, but that data is not captured at a national level or even at a state level, so I think that's a future thought process.

The other thing that I wanted to point out, and I think everybody is fully aware of this, we have ACOs. We have health homes. We have behavioral health homes. We have integrated health homes. We have health care homes in Minnesota. We have advanced medical homes in North Carolina. We have patient-centered medical homes under NCQA in all of our markets, and so -- and we have CCBHCs -- and how are we taking all of these who were trying to get everybody to do integrated care, which is the right direction to go in in my view, how do we take all of these activities and align them? Because when we start talking about reimbursement mechanisms, then you have duplication of reimbursement because if you have somebody in a behavioral health home who's also aligned with an ACO, and that ACO, the attribution of the behavior health homes, which is great that Minnesota has created that attribution, but in most markets it's not, it's the primary care physician.

Attribution and behavioral health is carved out, so how we align all of these different great provider-led programs at a community level into a singular -- and maybe NCQA can do this because they've got their fingers in all of these pots -- is figure out a best practice that crosses over, and then a best reimbursement mechanism because what I do know is that what we struggle with is the ability to not duplicate payment for services for care management and not duplicate care management, and so that's difficult but doable, but the biggest thing is payment. If you're trying to put providers at risk, and there's a total cost of care, this is a real quandary, and these are all great programs, every one of them, but I think just from a future state, I wanted to call out the alignment of all of these programs. And when there's multiple programs in a state, the management of those programs is very critical, and figuring out that all we're going to do on the back-end is collect data or feed data to these different types of programs, there is a clinical oversight in my view that needs to get done so that those members who are most at risk are getting case conferences amongst all the treating providers, are being able to be at the table and managing these members in a different way. So that's just my soapbox that I'm on today, and I appreciate the opportunity to really talk about this because they're all great programs, but I think we have to look at it of how are we aligning these programs from both a practice and a payment methodology?

Dee, thank you so much for sharing those insights about the complexity. Really very much appreciate that. Theresa, you're next. Jim, did you have another comment?

Oh, just in response -- we've been working on this for some time, and to the last speaker, one of the ways that we have brainstormed and hoped to move to eventually is to create a non-risk-bearing regional care organization, very similar to what's happened up in Vermont and North Carolina, and so you bring together all the players, and it's not just the medical players. You bring together the social services, the Department of Family Services, corrections because corrections has a lot of overlap with the same clients, housing as well as the hospital, primary care, and specialists. You continue to pay -- they sign a contract, but it's a non-risk-bearing contract, so that -- and then we could pay, you know, use some of the health management fees, and we could pay for the care managers so there's no wrong point of entry, and then if they are able to meet the savings goals, you share half the savings back to that organization to redistribute because there's going to be winners and losers. Primary care is going to be a winner. Hospitals and specialists will probably be a loser, so share the savings with those because you need to keep them. So there's a lot of support for that. We just need a little more infrastructure, but that's how we're hoping to transition from a pure fee-for-service to an APM to eventually an ACO. So I just want to share we've been thinking about this for a couple of years now.

Thanks, Jim. In a minute I'm going to bring that back to measurement, but first, let's hear from David.

As I hear about the data complexity, both in the newer metrics that we're talking about as well as some of the other hybrid ones, I keep going back to my prior point as far as there's so much variation between health homes on their, let's call it data maturity. I wish there was some sort of metric, and it seems like it's a gap here, but there was -- I don't know if it's a rating or a data completeness, data sophistication metric that could help us interpret the data from all these various sources because for example on the two new items we added, the A1c and the colonoscopy metric, if I saw a low data sophistication metric, say, for one home, then I would know just ignore those two metrics because they aren't representative of the actual clinical care or the coordination care that's going on. It's just a byproduct of the data systems whereas if I saw a high one then I might pay attention to that one and know that that's more meaningful for performance improvement type of stuff and for that particular home, and so that seems like the gap to be able to understand what challenges the individual home is facing and how far along the journey they've come so far, and not in a punitive fashion, but just to understand where they are in that data journey.

Yeah, that's a great point, and it's something that we have worked on for many years as part of the Core Set and more generally in our work with the T-MSIS and TAF data, the Medicaid data, of really thinking through, first of all, what are the data quality issues, and then also what are the deviations from the Core Set specifications? So what you would find in a state-specific comment is information about, what's included, what's excluded, where there were some deviations, where states had caveats about the data being reported. So I think it's hard to come up with one metric of data sophistication and data maturity. I think that's something that we've learned quite a bit, and it's something that fits every single measure because every measure uses different types of data elements.

So I think the most important thing is transparency when health homes, state SPAs, report data to be really transparent about what's included, what's excluded, and where there are deviations. And I think then the data can begin to speak for themselves, and it is something that we look at very closely. We have a process called, what we call, “seek more information”, or SMI, that is part of our data quality review process, and in fact we're just finishing up that process for the FFY 2020 Health Home Core Set data. So I think that over time the data get better, and I think that there are some known challenges with certain measures.

I think you pointed to a couple of measures that have been suggested for addition that I'm sure we're going to be learning a lot more about the challenges over time, but I think the main thing that I would like to emphasize is the need for transparency when states, SPAs, programs report measures where they see the challenges with reporting. So I think it's something that we consider also for the Child and Adult Core Sets and are working on that as well for those Core Sets. So thank you.

Other comments. Other gaps. Any specific areas or any that we want to bring back from the conversation that we've just had about innovative models, innovative ways of coordinating care, aligning care? Any specific measures? I know we talked about experience of care earlier, and we talked about depression screening, how the current measure isn't the best. I think one of the things I certainly heard is that as there's more electronic data, we'll have more capabilities. Curious if there are other comments that people want to make before we move on? Dee?

Okay. Final comment. I think for our care managers, having some decision support tools that tie to the work that we want them to take action on would be a very good opportunity for all of us to figure out how to create decision support tools for care managers at a layman's level because they're not all clinicians and be able to say, "If we're going to say this is the Core Set of measures. You know, based on this assessment, here is, you know, a positive response here means that you need to do XYZ." I think having a decision support tree for care managers is something that we should consider for future work efforts.

That's great. That sounds a bit aligned with some of the quality improvement work that we try to do that ties back to the measures, to try and move from collecting and reporting the measures to actually using the measures with change strategies, interventions, and so on. Thank you.

All right. Well, let's move to the next discussion topic at the bottom of this slide which is a couple future directions that we've identified plus there may be some other directions that you all have in mind.

So the first we'd like to talk about is measures for the Advancing Care for Exceptional Kids or ACE Kids Health Homes, and I know at one point somebody mentioned ACEs. This is a different ACEs, and so we'll talk about this in a second what we mean by ACE Kids Health Homes. Then we'd like to discuss other strategies for using health home measures to improve quality and then open it up for any other topics for future direction. So next slide, please.

So this slide contains some brief background on ACE Kids, and as you can see here, section 1945A of the Social Security Act provides states with a new option for health homes for children with complex medical conditions, and states must submit a state plan amendment or SPA to implement ACE Kids Health Homes, and the anticipated start date at this point is October of 2022. And so states opting to provide this coverage will receive an enhanced federal matching rate and then will also be required to report quality measures specific to the services provided to children with medically complex conditions. And in the future, ACE Kids measures would be added to the Medicaid Health Home Core Set. So next slide, please.

We wanted to use some time now to just do some brainstorming. This is high-level brainstorming, none of this is binding in any way, to think through what would be some good measures for ACE Kids Health Homes that are charged with serving children with medically complex conditions and usually very rare conditions. So it would be very hard to think through condition-specific measures, for example, thinking a little bit more broadly about the kinds of services that we want to promote through the Health Home Core Set for ACE Kids.

And so this slide shows some illustrative measures for monitoring the performance of ACE Kids Health Homes. Like I said, they're for illustrative purposes to facilitate Workgroup member feedback on potential measures. This list is largely aligned with measures in the Child Core Set or measures that have been recommended for addition. So we won't be formally recommending measures. We won't be voting on measures, but just trying to brainstorm about measures, including those on this list and any other suggestions you might have. So now I'd like to open it up to Workgroup members. Who wants to go first? Jim, did you have a comment, or is your hand still raised from before? Well, let's move to Dee.

So am I understanding this correctly, this is for these are medically fragile children that would go into this ACE Kids Health Home?

Yes, that is correct.

So for medically fragile children, I think a more important aspect of that program would be that we have clinical teams that are managing these children. Problem that we have when we get medically fragile children added to our current health home mix is that the health homes themselves don't have the clinical bandwidth. They're not associated with a neurologist, those kinds of practitioners that treat these children, and so we tend to feel like they're not getting the proper level of care. Even though it's a care coordination aspect of the work, they're not embedded with the treating practices, the pediatricians, the neurologist. You know, many of these children are on trachs, and, you know, they're just complicated kids, and I agree they need care coordination, but if it's not being performed by a nurse, you know, you're setting the family up for not having well-coordinated services or a care manager that doesn't know the right signals to determine that there's trouble for this child.

So I think first and foremost that's my comment about the ACE Kids Health Home. I think the Core Sets seem fine because it's getting the routine level of care, ensuring the right dental care is being done. I think the CAHPS again, this is going to be a very, very small subset, so unless we modify the CAHPS we won't have the core measures in here, so I would vote no on that from a measure set for this group of children because the medically fragile is a subset of the health home population. So it's a very small group of children who are in need of a lot of wraparound care, and typically in the states that have added this into the health homes, we are definitely duplicating care management, which I know is something nobody wants to do, facilitating a care team for these children between a managed care company and an external health home with clinical leadership and medical directors and pediatricians at the managed care company trying to couple with non-licensed staff at an external health home is very hard to do. So I think I know that this is a future state and you're really looking at doing this quickly. I think that needs to be a big consideration.

Thank you. That's helpful. Karolina.

Yes. Thank you. I will echo what Dee was saying. From my experience working with providers who help kids with medically complex conditions, what I've noticed is that the measures, particularly the measures that you have here on the screen, are the measures that probably they won't be really interested in and might even consider not, like, the things that we should be measuring for kids with medically complex conditions. I think maybe doing some type of evaluation of what providers who treat that population of patients, what do they think is most important to measure maybe would be a good next step just from my experience working with providers who help kids.

Thank you. That's helpful. Linette?

Thank you for unmuting me again. I guess maybe just to echo some of what's been said, but one of the things I know we've talked about at different times is for the children that have these complex health conditions, it can be that the standard preventive measures get overlooked in the care, and so having, like, the ones that are essentially your well-child visits, your immunizations in particular, the oral evaluation are things that by having it as part of the measure set seems like it would help highlight it as something to do as part of the health homes process because it's really about that care coordination and making sure preventive services occur as well as treatment of the particular conditions. The other ones that are listed, like the follow-up for hospitalization and ED that are listed here, and the CAHPS, I think those might be more challenging to do just because of some of the things we've already talked about over the last two days in terms of population size and those kinds of things related to reporting, but having the balance between your core preventive services that every child should receive as well as then looking at some measures that perhaps are specific for this environment that folks have been talking about seems like that might be a nice balance as you think about it in the future. Thanks.

Thanks for that, Linette. Kim Elliott.

Yeah, when I'm thinking about measures for complex populations and kids in particular, it really comes down to a lot of things for me, but it is of course managing the chronic condition but also ensuring that that child can be the best that it can be, he or she. So things like any developmental screenings, care coordination and the complexities involving this type of population, any follow-up measures that are out there and available that would be applicable to this population, even things like medication management, those are the things that I see quality failures on that have an impact on the members being served in health homes.

Thank you. Fran?

Yeah. I mean, we've done a little research in this. We have about, across the state about 700 of these kids, and the biggest challenge they have is that oftentimes getting the right services based on the workforce availability if they need private duty nursing or something is a real challenge. I'm not sure what a measure could be about these, but to that point it's very frustrating for parents, so if we're going to have a measure, if we're going to measure this, we should absolutely have some way to work with the parents to see what would be helpful for them and the providers.

The other piece would be -- I had a thought. It was a good thought. Oh, I know. We want to I think -- one goal would be to keep them in the community as much as possible, either at home, and so we're not, you know, not in the hospital or nursing facility, long-term care facility, so maybe there's a measure there, but maybe now that I think about it, I'm not sure how many -- what that would really be measuring in terms of how many institutionalizations happen over time. I'm interested to hear about what people think this kind of health home that is supported clinically for sure, can a health home effect that change? Because sometimes placement is so difficult for these kids. Obviously. I just said the obvious.

Thanks, Fran. So I have a question for the group. Well, we heard loud and clear that there is no interest in adding CAHPS to the Health Home Core Set, and we heard a lot of good reasons why CAHPS might not be applicable to this population, both in terms of the survey and methods and other considerations. I'm curious whether any of the programs represented here utilize any other kinds of assessments of family experience. There is one that I'm aware of called Family Experiences with Care Coordination, and it was actually developed as part of what's called the CHIPRA Pediatric Quality Measures Program. So it's very focused specifically on children with complex needs and I think gets at a lot of the same kinds of issues that were discussed about concerns that families have about the adequacy of the care coordination. I'm curious if anybody is familiar with that survey or with any other instruments or tools for trying to elicit family experience.

Kim, did you want to speak to that? Kim, you have your hand raised. Do you have a comment?

Nope.

Okay. Then why don't we move on. Pam Lester.

I'm really excited about ACE Kids. One of the things that we found in our chronic condition health home is that there really wasn't a way to capture eligibility for this population, and we found a lot of frustrated health homes, which our chronic condition health homes are a primary care provider, so they have primary care provider and a nurse care manager. But we couldn't get them enrolled, and this program would really capture that population that we just struggled because they didn't have any ways with regular chronic conditions, and again, there was just no way to capture maybe all the conditions that would fall under this health home program. So I'm very excited about that, and then as far as measures go, I think I agree with a lot that was said.

The Adolescent Well Care and the Immunizations for Adolescents I think are really important because over the years that, you know, typically you see children kind of disappear, and I also, one of the things that actually hasn't been brought up, and it's a passion of mine, is transition from peds to adults. And we have kids that have complex needs that are living longer and longer, which does potentially set them up for institutionalized care as an adult, potentially. So is there anything that we could build into that to really help with that transition? And that's an important transition that I think a lot of times isn't thought of. Usually we think of ED and hospitalization transition, but would there be any ability to focus on that?

Thank you. Linette?

Sorry, I'm still learning to put my hand down.

You'll figure it out before we're done. Thank you. Dee.

Thanks.

Oh, yeah. Thanks. I love what Fran said. I think -- to some of that by better defining closed-loop referral tracking so that we can -- because that is indeed a parent care coordination nightmare. That something is, you know, defined as being needed and then can't get completed. So I think that, I think another measure that, and I don't know if there's, you know, a HEDIS measure that tracks this, but ADLs and the ability to manage the ADLs would help prevent as early chronic condition children are able to grow into adulthood if they're being able to manage their ADLs better, I think that's a very big issue to create that independence capability. So I don't know if there's a measure that does that, and I do not have the experience of the CHIPRA Family Experience with Care Coordination. I would be interested in seeing more about that.

Great. We'll share that after this. Anyone else? All right. Can we go back to slide 92?

And I wanted to move on now about strategies for using health home measures to improve quality. I think our earlier conversation was starting to move in that direction about how can we develop decision tools? How can we use the measures to improve quality? And I was really impressed by the conversation yesterday as well before we kicked off the conversation on the individual measure review. Any other thoughts about strategies for using health home measures to improve quality? Any areas that you'd like to see technical assistance or support from CMS or support from each other about areas for using health home measures to drive quality improvement? Fran?

Yeah. I was just wondering, I think data, you know, collection is key. Looking at your metrics is also obviously one of the keys to improving quality, but I was wondering, and this goes to the sort of clinical decision-making tools that can help perhaps. This may come out -- I'm not trying to offend anyone here. Like, what are the skills that a care manager has or needs to implement, to understand and implement something for change? Do they have the quality improvement skills and understanding of what the measures mean, how you design programs to address the measures? It's more of I'm just asking not -- I'm hoping this doesn't come out as a criticism.

And I'll turn that -- well, not turn it around, but add to that in terms of, are there areas that CMS can help build capacity?

Yeah.

You said that much better than I did, as usual.

Well, I'm thinking a bit about the kind of work that we're doing in quality improvement with the Model for Improvement. So really trying to figure out how to use measures, use information to drive improvement using a more evidence-based, science-based process. So with that, Dee, I think you're next.

Yeah, that is why I brought up the decision support tools earlier is that I think you're right that not everybody is equipped to understand, "So what? Now that I know this, so what?" and really creating some decision support tools that are readily available to all care managers. Maybe we break it up into different population groups or whatever, but make sure that people know if you see this, then create this action associated to it because that will drive not only the quality improvement, but the practice transformation in a health home will really start to occur where care managers are better equipped. To Fran's point, I think, you know, not every care manager is familiar with motivational interviewing skills, right, or well equipped to do it even if they've attended a training, making sure that they understand the populations and ensuring that care managers have good safety mechanisms associated to treating members in their homes and treating difficult members and treating members who have, you know, cognitive differentials.

So I think all of those things are things that we could help the care management community because there is a workforce shortage, for sure, both in pediatric psychiatry, pediatricians, specialists that deal with the children with these very chronic conditions, and the more we can do to help embody that workforce with better decision support tools that would drive them to do that quality improvement, the better care all of the population will receive, and that's the end goal in mind is to get better care for all of the members who have all of these conditions.

Thank you. Karolina.

Yes. Thank you. So I was thinking about tools that could -- a lot of quality improvement obviously happens in this area of understanding what's happening and using the data to evaluate the program. Maybe identify patients who need follow-up care, and it's based on data, but a lot of quality improvement happens, you know, in the relationship between the provider and the patient. And if the patient doesn't, you know, have trust in the provider, then, you know, data will not help if that trust doesn't exist. So I was thinking especially in regard to racial inequity that, you know, any tools that could help us better understand how you build trust in that relationship. How do you better understand the community that the health homes are, you know, providing services to? How do we engage with the community? Because I think ultimately, you know, quality improvement happens in that area.

Karolina, I have a follow-up question for you. Does your health home program have good information on the race, ethnicity, and other characteristics of its population to be able to do stratification and look at variation and then be able to use that information to narrow disparities and advance health equity?

I want to say that we do, but we have not stratified our Core Set measures by race and ethnicity, but we do plan to do it this year for the first time. And, you know, a lot of the measures that we look at are NCQA measures, and NCQA just recently came up with some ways of, you know, like, standardized ways of categorizing race and ethnicity, so we will be using that, and we are using a lot of information that we obviously get in the Medicaid program is from enrollment data, but we are also supplementing that information from MMIS, from Medicaid enrollment, by other data sources that are available to the Medicaid agency. So I think we're going to get, like, 90 percent of -- maybe I should not say numbers, but we're going to have a pretty good insight this year, and we'll be stratifying this year our results by race/ethnicity.

Oh, that's very exciting. Thank you for sharing that. Pam?

Yeah. Some of the things that I thought of around improving quality is, and the things that we use in Iowa is the Donabedian model, so making sure that our state plan amendment has really the structure to articulate the requirements. Another thing that we're in the process of implementing, trying to work with the providers to help get their input on it is a self-assessment tool that helps them ensure that they have all the policies and processes in place to make sure that they're really meeting all those requirements. And it's an Excel tool that tells them if their policy or the process is in the beginning, is it approved? Are your staff following the processes? If not, do you need training? Do you need to update the process because what your staff is doing is better?

So trying to create those tools for them to help them be independent and have that to assess that. And then, of course, outcomes, looking at their documentation and doing those reviews and having them do performance improvement plans, and then we have the learning collaborative, like I had talked about yesterday morning, and we used that as a way to also help. I did a presentation on an A3 I was so excited about it because I'm a geek with this stuff, and I tease them all the time. I also talk about storyboards because that's a good way to show those different steps in quality improvement. I don't think they're excited about that either. I'm probably a lone wolf in that, but those are some of the things that we do to really help kind of give them the tools that they need for quality improvement. And one thing that we're actually focusing on this fall is culture, to change the culture, because if we don't have the ownership in the program and the ownership of all of these requirements and team-based care and things like that, we're really not going to be able to really make a big impact on our population. So those are some of the things that we're working on and engaging with. I heard Karolina talk about engagement with members, and that's something that we really need as well because I think that there's a lack of understanding and engagement, and I haven't gotten to be able to do that yet, but it's definitely something that we need.

Thank you. Jim Bush. There you go.

So a couple of thoughts because one of my primary focuses is around quality improvement for Wyoming, and we've got a lot of measures, like our A1cs and our colorectal cancer screenings that are very clinical and really are in the hands of our physicians and nurse practitioners, but I'm also hearing a lot about the care managers and the case managers, especially around the health homes. And I learned a lot about the differences as I'm helping our home and community-based services team, you know, because now CMS has quality metrics for them, and initially, I was going, "These aren't clinical quality metrics," and they're going, "Yes, but there are other things about quality of life, housing, mobility, et cetera." And so I think that's an important distinction to keep in mind because we've sort of seen all types of these four measurements coming together, and so we've got to remember not only is it here at the health home, but who is the provider in the health home?

One example for non-clinical people, because depression screening is very important to us, is we actually wrote out a list of, "What are the scores for PHQ-9?" and so if the person has the PHQ-2 for depression screening, would that trigger a PHQ-9" and then depending upon the score of the PHQ-9, just what should a layperson do? And we give that to them, and even then, we're finding our care managers and case managers aren't following the recommendations we gave them, so that's a very important thing. But the other thing, and, you know, anyone who's been through QIP quality improvement training, just to get a measure, we find we have to go back and sit down quarterly with all of our practices and review where they are, see where they're trending and actually give them the deliverables and say, "These are the ones where you're missing out on." And even then, for the providers, they're not as interested in their scores because there's no real penalty yet.

So getting them to buy in, we're finally getting the buy in after about three years of the patient-centered medical home, so -- but I've just noticed over the last two days that depending upon which measure, you know, not only is this all aimed at the health home, but which provider in the health home, and how did they do this, and then how do you get improvement? Because to just record a measure means nothing. Is this an acceptable level? What is an acceptable level, and then how do you do it through the PDMP cycles? So I just felt that was important to mention that because I've had so much learning I've learned about the different providers, and when I came at it from a strictly physician standpoint, so those are just some thoughts I wanted to share.

Thanks, Jim. That's really helpful, and I've also had similar questions listening to all the comments the last two days about how people approach measurement and relating it back to the way the programs are organized and what their goals are and what populations they're serving, so that's a great insight for this section.

Any other future directions before we move on to the next section? Last call. All right. Next slide, please. So now, next slide.

Thank you. So now I'll hand it back to Tricia, and she's going to be soliciting reflections and feedback from the Workgroup and our final public comment period before we wrap up. Tricia, it's all yours.

Thanks, Margo. Next slide.

So we have had such a great discussion over the last two days, everything from the use of Health Home Core Set measures for quality improvement to a discussion on the specific measures and now gaps and future directions. The Workgroup formally discussed three measures that were suggested for removal and five measures that were suggested for addition. Two of the measures that were suggested for removal passed the two-thirds vote of the Workgroup to recommend them for removal, and just to recap those, they were Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment and Screening for Depression and Follow-Up Plan. And then of the five measures that were considered for addition, two of them passed the Workgroup recommendation on a two-thirds vote, and those were, Follow Up After Emergency Department Visit for Mental Illness, and Colorectal Cancer Screening.

So at this point in our agenda, we'd like to take a little time to reflect on the process, and we have some topics listed here on the slide. The first topic we'd like Workgroup reflection on is whether there are opportunities for providing technical assistance to strengthen Health Home Core Set reporting. So we got to this a little bit in the previous conversation, but I just wanted to open it up to see if there are issues related to data collection and reporting or other topics CMS could provide technical assistance to health home programs, especially particular to the two measures that were suggested for addition, so the, Follow Up After Emergency Department Visit for Mental Illness and Colorectal Cancer Screening, and then also opportunities for technical assistance more broadly on the use of measures for quality improvement. So I will stop there and just see if there are any other comments or thoughts from the Workgroup on opportunities for technical assistance either on the measures suggested for addition or on the use of measures for quality improvement. Feel free to raise your hand, and we'll call on you in turn.

Dee, go ahead.

So I found myself reflecting a lot during the last two days because I oversee multiple states and how they operate, and so it's interesting to me to hear one state's opinion versus another state's opinion, and I think it's really important that we continue to collaborate across all of the health home programs. So from a technical assistance perspective, I think it is important that we align all of the states on the core measures. I also want to thank Mathematica and CMS for the opportunity for this review process to happen. I think it was really beneficial for all of us to understand not only the program perspective, but what did the quality scores mean and what can we do and how can they better the program. So I really appreciated that opportunity, and I just wanted to applaud everybody who's participated in this. It's been a wealth of knowledge and a lot of great information, and I think if there is technical assistance, it definitely should be available to not just the state level, but also down to the provider level who are influencing how well we do or don't do this and then be able to hear back from the health home providers who are doing this work understand what they feel and what can they offer to this quality Core Set, and maybe they have different ideas from what we may have thought were the right things and the right directions to go.

Thank you, Dee. Any other Workgroup members with ideas for technical assistance? And this could be use of measures for QI or any of the other measures that are on the Health Home Core Set that states may struggle to report or have any barriers that they've come up against.

Karolina?

Yeah. There is -- I think what would be helpful is, technical assistance being, "How to use the prevention quality indicators for quality improvement?" Those are those prevention quality indicators where it's kind of, like, a little tricky measures, similar to the AMB measure that we discussed yesterday. I hear from providers often that they don't know how to improve on these prevention quality indicators, so I think that would be helpful.

Thanks for that suggestion, Karolina. That's really helpful. There's a PQI measure in the Health Home Core Set and several in the Child and Adult Core Sets as well, so I appreciate that suggestion. Sorry, just the Adult Core Set. I misspoke.

Dee, go ahead.

Yeah. No. And just to pile on a bit, but I think the technical assistance, if we can provide to the providers who are doing this work, we'd not only understand the core measures but also the understand decision support associated to what they find out from the quality scores, what can they do to create practice transformation? What kinds of trainings do they need to look at for their staff? I think the real work is done at the provider level, so I really want to figure out a way for that technical assistance to go deep within the provider organizations and tie some of those decision-support tools that we were talking about into that technical assistance.

Thank you for that. Fran?

Yeah. I can't remember who was talking specifically about this, but all the, I think it was Dee, all the various terms and opportunities for care improvement, to that point, really get a better sense of the various roles and responsibilities. So what is a care manager? What is a case manager? What is a care coordinator? And by function, not necessarily by, you know, person because one person could do a couple things. Right? But the words get confusing, and some of the work I did previously was, you'd have to then -- you'd have all these care coordinators, and patient advocators and community-health workers and all that. You'd have to hire a care coordinator to coordinate the care coordinators. So just getting some serious clarity on what a team could look like and the functions as opposed to the person. So form should follow function. That's always confused me a lot.

Sure. Thanks for that. Pamela, go ahead.

I think one thing that would be helpful, and I know it's been mentioned, is what measures, what provider measures, could help them make an improvement on a specific measure? Of course, the easy one would be, you know, colorectal screening, you know, having a report that tells them the percentage of people that have or have not and then a list of those that have that gap in care. But I think having the ability to share with them what provider measures go along with the payer measure would be wonderful.

Yeah. Thank you for that. Are there other comments on technical assistance needs? Karolina?

Yeah, I just had another thought that, you know, we talked about quality measures, but Health Home Core Set reporting includes that cost-savings analysis, and I think that technical assistance, some suggestions on how to do it would be helpful. We developed a methodology. It took a long time to figure out what to look at, and usually shows savings related to avoided ED visits or things like this, but more technical assistance in that analysis would be helpful.

Thank you. That's really good to know. Pamela, I see your hand is still up. Did you have something else to add, or is that just from before?

Sorry. I forgot to put it down.

No problem. Okay. I'm not seeing any more Workgroup members with their hands up on that topic, so I'd like to move on to the last topic on the slide here. As you all know, this was our first-ever stakeholder review of the Medicaid Health Home Core Set, and so in the spirit of continuous quality improvement that we've been discussing for the last two days, we'd like to solicit input from the Workgroup on how we at Mathematica could improve the process. We are interested in your feedback on all aspects of this process, from these meetings to the materials that we've prepared and distributed to the Workgroup, to the meeting platform and voting and anything you can think of. So I see a few hands are up. Karolina, do you want to start?

Yeah. Thank you. I just wanted to share my appreciation and gratitude and just give kudos to the team. I think the materials have been so helpful. Thank you for sending them ahead of time, and the platform, the voting platform, worked out really great, so I just want to give you kudos. Great job.

Thank you. Cindy?

Thanks. Yeah. I want to echo Karolina's comments in terms of the smoothness of the running and the thoughtfulness of the preparation materials. You know, Mathematica has really done a fantastic job with this. I had a couple of thoughts about potential improvements. One was, and I don't know if anyone else shared this feeling, but I felt a little over-reminded. When I get, you know, four reminder e-mails, I start zoning out, and so you understand might want to think about how many you're sending out., But more importantly, I would like to suggest that this process start by convening the Workgroup to discuss the current measurement set and gaps and issues. Because the process as established is, you know, the first thing is we get requested to, you know, requested to suggest measures for addition and deletion, and we talk about the gaps at the end of our voting process, and that seems a little backwards to me. So, I think that one of the problems with this, you know, considering every item separately and voting each one up and down separately is, you end up with a collection of strong items, measures, but it's not a real measurement set in terms of how -- there's no assessment of how these -- have we filled the gaps? So just maybe some thoughts about how to get it to a place where we feel more like, "Yeah, this collection of measures is something we're endorsing as well as each individual measure meeting standards."

Thanks, Cindy. I appreciate how thoughtful those suggestions were.

Pamela?

I have just enjoyed this experience. It's been great. The functionality and the set up was really great. I appreciated it. I also appreciated hearing perspectives from other folks of different backgrounds. That has been really great as well, so I appreciate all of that.

Thank you. Any other Workgroup members with suggested improvements for next year or other comments on the process? Fran, go ahead.

Yeah. I thought it was great. I really learned a lot, and then I appreciate everybody's different perspective. I just had a little trouble with the Box thing with all the documents, and I'm the first to admit I'm kind of an IT novice, but I just had to keep signing in, and then that was just kind of -- like, finding the documents was not entirely easy, but that could just be a Fran-ism, not a, you know, global generalization.

No. I appreciate that because this is actually the first time we've used that platform. Was it just that the organization of the documents wasn’t intuitive, or do you think that the platform itself -- sorry to ask for a little more information because we're still figuring out what the right platform is for this purpose as well?

Yeah. I think it was maybe the instructions. Because it, like, getting back onto it -- so you sign in. You know, you get your password and all that sorts of -- you get an account, and then it's hard to, like -- and then I would close it out, and finding it again was a challenge. But again, it could be just me, so, like, I'm -- like I said, I'm not particularly IT. Like, I hate Google Docs and all that sort of stuff, so it could be -- it could just be me. I don't know. And then the only other thing that I was just confused about -- and I love the polling. I'm glad that we didn't have to submit our paperwork. You know how, like, sometime to send grant reviews, you always have to write stuff down and then submit it to the grant officer and all that sort of stuff, and we have to document everything to justify your conclusions? I liked the fact that we didn't have to do that.

Okay. Thank you. Dee, I think you were next.

So I agree with Fran. It's not a Fran-ism. I had difficulty. I had to go through my IT team to get into the Box. My thought process is, "Maybe there's an internet SharePoint that you could secure, and then all the documents would be there." I did like the voting platform, and as we're talking about technology solutions, one of the things I am thinking about is, you know, CAHPS is a mailed survey, and it comes back, and it's mailed in, and it's tabulated, and, you know, it's not technically in the times that we are living. So maybe thinking about, in the future, how do we get member experience? Because we send it to somebody's smartphone as, you know, a survey that they can just take on their smartphone and it -- or those -- you know, we don't get member emails for Medicaid members. It's not something that's typically captured very quickly, but we know everybody has them. So maybe for the future, one of the things we could think about is, "How do we create the feedback mechanisms in a more fluid, technically enabled way?"

So I myself loved the process. The voting, I think, was great, and I really appreciated Mathematica's giving of all the materials, the process for orienting us to begin with, convening the public commenters from a very rich resource for -- that we rarely get a chance to get them all in the same room, so feel very honored and appreciated by the fact that they all attended while we talked. It was a very good experience, and I learned a lot, so thank you, everybody, for the participation, and I think maybe the only thing is the Box that we could fix for the next go-round.

Yeah. Thank you for that. It's -- we really appreciate these comments from both you and Fran because Box is a new tool for Mathematica, and we were the guinea pig. I will be honest, but our internal group, our internal team, has said, you know, "Let's do our own little quality-improvement cycle," and we'll go back to SharePoint. We've used SharePoint in the past for these Workgroups, and it seems like that might be a better solution going forward, so thanks for the feedback.

And the only other thing is, you know --

Jim, you -- Oh, go ahead.

The only other thing I was going to say is, a lot of us are moving to Teams and may be thinking about that next time rather than WebEx, but I don't know how the voting and WebEx work together, so just, you know, disregard my comment if we're tied in any way.

Sure. No. Thanks. That one might be above my pay grade because Mathematica sets those standards, but we appreciate the comment. Jim, I think you were next. Go ahead.

Yeah, so in these days of heightened cybersecurity, I knew we were going to be getting some material, but then when the linked Box came in, I hadn't recognized the name, and so -- and, of course, our IT department is drilling cybersecurity like mad into us, so I didn't open it and deleted it. And so, of course, once I figured out, "Oh, that was what you all were talking about," so that was just one little hiccup because people are paranoid in state government about cybersecurity these days. I think the voting screen was interesting and worked well, but it was a bit of a challenge with two monitors having three screens open because I had my Box open. I had my voting screen open, and then you had the webinar open. I don't know if there's any way we can shrink them down, but once I figured all that out, it was -- you know, it worked smoothly once you had it set up and working. So I think on the whole it was good. That was my only time when I went, "What is Box?" And I didn't request that, so --

Yeah. That makes sense. Thank you. Linette, you were next. Go ahead.

Hi. So I think we've probably beaten the Box thing to death, and you've already said you're moving away, but the one thing I hadn't heard yet is literally our IT system blocks us getting into it, so you e-mailed it to me, so the e-mail was great. I had everything, fully appreciated that, and the only other thing I would really kind of say on the process is you guys do a phenomenal job. I've participated in the Adult Child Core Workgroup, and I'm always so impressed at how smoothly it runs, how well the pieces fit together. The voting has been great. I know it always takes a few minutes on the first round as we all get synced up again, but just truly appreciate all of the work that you put into both materials and the process, and I think it's truly exemplary. Thank you.

Thanks, Linette. I see Kim and then Cindy, so, Kim, go ahead. And, Kim, you might be muted in the platform.

Really a great process, and I think that the timeline allows for us to be able to do a really good review of the documents that are provided and to do a little bit of thinking about what might make things better, what might close gaps. I think that the platform that we're using for documents works. As we change different platforms, it takes me a little bit to figure them out, but once I figure them out, I'm usually okay, so overall great job.

Thank you. Cindy.

First, I wanted to respond to the comment about sort of electronic data collection around CAHPS or other kinds of experiences, and just to note that so far, efforts to go electronic have not increased response rates, so to maybe quote David, you know, we're not there yet. However, CAHPS is not just a mailed survey. There are multi modes, and so there are other options like phone administration as well.

The second thing about the measure nomination process, so when I initially looked at what we were being asked to complete in order to nominate a measure for consideration, it seems like a very high bar that, you know, that you're asking for lots of information and research and that sort of thing. Now it turns out that you guys did a spectacular job of supporting it on the back end where you do your own research and found out things and asked questions and pursued things, so I think that it was, you know, terrific support but that the initial ask may have made people a little reticent to come forth with nominations, so you might want to make it clear at the outset something like, you know, if you don't have this information, we can work with you to try and complete this or something like that.

Great, thanks for that. Libby, go ahead.

I just want to thank Mathematica but also thank everyone in the Workgroup. It was really helpful for me to hear other states' perspectives and other individuals involved in the health homework perspective and what different challenges and successes they've had, and I think it also helps me consider different pros and cons of measures. And so the only kind of recommendation or thought that I wanted to elevate or nudge a little bit was the earlier suggestion of having some of the discussion around gaps a little bit earlier just because I think it might help generate more suggestions or it would give, I think, a little bit more context during that review process. It would just have -- you would have a little bit of that information or a little bit of extra kind of, like, context while reviewing. Beyond just your experience, you'd get a little bit of information from everyone else too, so I thought it was a great process and really informative, and I really appreciated everyone's efforts. Thanks.

Thank you. Any other comments? I see, Kim, Jim, and Cindy, you still have your hands up. I'm not sure if that was from before or if there's anything additional you'd like to share.

Okay.

All right. Well, thank you all so much for all of that feedback. With this being the first year of the process, we really appreciate it. We appreciate your engagement. We appreciate your honest feedback as we work to improve every year, so thank you for sharing all of that.

Next slide.

So now I'd like to open it up for our final public comment period of the meeting. We invite any public comments on measure gaps, on future directions for the Health Home Core Set, opportunities to provide technical assistance to strength Health Home Core Set reporting, feedback on the review process or any other topic of interest. As a reminder, members of the public, please raise your hand in the WebEx platform if you wish to speak, and we will unmute your line. Angela Herman-Nestor, and please as we call on you, please introduce yourself and then share your comment. Angela, Derek, can we unmute Angela?

This is Angela Herman-Nestor with the Missouri Primary Care Association, so we work with our Medicaid primary care health home initiative. I just wanted to extend my appreciation for the opportunity for the public to be able to participate in the Workgroup meeting and hear the discussions and future directions and that type of thing because it does impact the work that we do at the local level. I would really encourage as you're looking at technical assistance needs and those types of things that there's an opportunity for input not only from the Medicaid programs but also the impact of the providers themselves that are actually collecting the information or providing the care to individuals, Medicaid recipients and, you know, some of those burdens of that particular piece, you know, just thinking about CAHPS and the burden on the Medicaid recipients themselves to really take that into account in looking at those disparities but also some of the social determinants of health that are really impactful to the folks that these programs are intended to serve.

So keeping that at the center and then also looking to see as you're looking at data not letting what's available via administrative claims be the stopping point but look for -- there are many vendors and many folks are looking at population health platforms and with NCQA going through the formal audit process for those vendors so that that is validated and removes some of that burden for the data collection for the EHR piece that you really move to that because there's a lot of value in the actual clinical values to look at the quality of the programs versus the data that you can easily collect via administrative claims doesn't always tell the story but wanted to greatly appreciate the opportunity to be able to participate and comment.

Thank you for that comment. Any other members of the public who'd like to make a comment, please raise your hand, and we will unmute you. All right. Well, I am not seeing any other hands raised, so why don't we go to the next slide, please.

Before we adjourn, I would like to briefly discuss the next steps in this review process. Next slide.

So this graphic is a visual representation of the milestones for the review process, and we've seen this red box move down the slide over the last several months. We started off by convening this Workgroup with an orientation meeting on April 27th, and the next day on April 28th, we opened the call for measures for the 2022 Annual Review. On August 3rd, about two weeks ago, we reconvened the Workgroup to prepare for this voting meeting. At that point, we introduced the measures suggested for consideration for the 2022 review and described the process used to vote on the measures. Over the last two days, the Workgroup has discussed and voted on those measures that were suggested for addition and removal. So now we move into the right-hand side of this graphic, and this process will culminate in the development of a report which summarizes the recommendations of the Workgroup. The draft report will be made available for public comment in October, and then the final report will be released in November. The final report along with additional stakeholder input will inform CMS' updates to the 2022 Health Home Core Set which will be released by December 31st, 2021.

Next slide.

If you have any questions about this process, you can contact our team at the e-mail address listed here on the slide. It's MHHCoreSetReview@mathematica-mpr.com. And before we adjourn, I'd like to invite our co-chairs Fran and Kim to provide any closing thoughts or remarks they'd like to share. Kim, would you like to go first?

Great information, good experience, and it really did reflect directly on the measures being discussed. I think that members of the group also did a really great job of identifying different gaps and thinking about what would really make a difference from a quality perspective, performance perspective for the health home and how it could be measured, so I just think it was a great process, and I know everybody puts an awful lot of work into reviewing prior to the calls and then of course dedicating this time and really putting in a great effort through the discussions, so thank you, everybody, for that. It was a great meeting.

Thank you, Kim. Fran.

Yes, again just wanted to thank everybody for their time and effort. To be perfectly honest, I was -- dreading is probably not the right word, but 8 hours, 9 hours in webinars in two days is a little challenging for me and my dogs, but it went really quickly, and I learned a ton, and I really appreciate everybody's input and am very impressed with people's commitment, and hopefully we can stay in touch a little bit if we just want to learn from each other. There's a lot of great stuff happening in various states, and, you know, if you've seen one Medicaid program, you've seen one Medicaid program, but I do think there's some alignment and just additional exchange of information that would be great to continue, so again, thanks, everybody, for their time. This was really fun.

Thanks, Fran. I personally was a little sad that we didn't have any dogs in the background. I can't believe we made it through two meetings with no barking dogs, so congratulations.

Oh, I can make that happen. If people just start clapping, my dogs will start up. Yeah, or maybe the UPS guy can come.

But anyway, I wanted to thank you, Kim and Fran, for your willingness to serve as co-chairs of this Workgroup. We are so grateful for your leadership and your support as our team implemented this process. So the other thing I just wanted to briefly mention out loud is that the draft report when it is ready will be on our website, and you all will hear from us when it's available for public comment, so we'll make sure anyone who attended this meeting gets a notification when that is available.

Next slide.

All right. Well, thank you to everyone for attending this meeting over the past few days and for your engaged discussion and feedback. The meeting is now adjourned. Take care, everyone.