Medicaid Health Home Core Set Stakeholder Workgroup: 2023 Annual Review Voting Meeting Transcript July 19, 2022, 11:00 – 4:00 PM ET

Welcome, everyone, to the 2023 Medicaid Health Home Core Set Stakeholder Workgroup Voting Meeting. My name is Eunice LaLanne, and I'm a Health Associate at Mathematica. Before we get started, I'd like to cover a few housekeeping items. 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 raised 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 are using the browser or mobile app can find the raised hand icon by clicking the ellipsis icon. You'll find the option to raise and lower your hand in that list. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak and remember to lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this webinar. Please use the Q&A feature if you need support.

If you have any technical issues during today's webinar, please send the Event Producer a message through the Q&A function located on the bottom right of your screen. If you're on the browser or mobile app, look for the question mark icon. If you're having issues speaking during Workgroup or public comments, please make sure you're not also muted on your headset or phone. Connecting to audio using computer audio or the ‘call me’ feature are the most reliable options. Instructions for adjusting your audio are on this slide.

Now I'll turn it over to Margo Rosenbach.

Thanks, Eunice. Good morning, everyone. My name is Margo Rosenbach, and I'm a Vice President at Mathematica. I direct Mathematica's Technical Assistance and Analytic Support Team for the Medicaid and CHIP Quality Measurement and Improvement Program, which is sponsored by the Center for Medicaid and CHIP Services. I'll be facilitating the meeting today because Tricia Rowan is feeling a bit under the weather. So it's my pleasure to welcome you to the Voting Meeting for the 2023 Review of the Medicaid Health Home Core Set. Whether you're listening to the meeting live or listening to a recording, thank you for joining us.

Next slide, please.

Now I'd like to share with you the objectives for this meeting. First, we'll review the measure suggested for addition to the 2023 Medicaid Health Home Core Set. Next, the Workgroup will recommend updates to the Medicaid Health Home Core Set. We'll discuss gap areas and areas for future measure development. And finally, we'll provide an opportunity for public comment.

Next slide.

I wanted to take a moment to acknowledge my colleagues at Mathematica who are listed here. This has truly been a team effort to prepare for the meeting in terms of both the content and the logistics. I also want to acknowledge our colleagues at Aurrera Health Group who will be helping to write the report that summarizes the Workgroup discussion and recommendations.

I'd like to pause for a moment and note that we are committed to a robust, rigorous, and transparent meeting process despite the virtual format. That said, we acknowledge that attendees may continue to face challenges working from home and I hope everyone will be patient as we all do our best to adhere to the agenda and fulfill the objectives of this meeting. Some of you may be wondering why we are not using video for this meeting. We found that some of us do not have enough Internet or Wi-Fi bandwidth to support video.

I also wanted to remind the Workgroup members of a few ground rules for participation today. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a Workgroup, however, you're charged with recommending Core Set updates as stewards of the Medicaid health home program as a whole and not from your own individual or organizational perspectives. So please keep this in mind during the discussion and voting. Second, we know that spending several hours in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning from the break later this afternoon so that we can have everyone present for the discussion.

And finally, we want to make sure that all Workgroup members who wish to speak may do so. The WebEx platform we're using will enable you to unmute yourself when you want to make a comment or ask a question. And if you find that you're unable to jump into the conversation, please raise your hand or contact us through the Q&A feature; and we'll make sure you have a chance to speak before we move on. Finally, we encourage Workgroup members to not repeat comments made by other Workgroup members and instead to build on the discussion with new comments.

With that, I would like to turn to our Co-Chairs, Fran Jensen and Kim Elliott, to offer their welcome remarks.

Kim, I think you're going first today.

I am, thank you, Margo.

Welcome, everyone, to the Health Home Core Set Stakeholder Workgroup Meeting. I really do want to thank Mathematica/CMS/CMCS for convening this Workgroup because this is such important work. The Health Home Core Set Stakeholder Workgroup is charged with assessing the Medicaid Health Home Core Set Measures. We also want to identify any gaps in the Core Set, as Margo said, and make recommendations that will really strengthen and improve the Medicaid Health Home Core Set. These Core Set meetings really are important. We often hear, "What gets

measured gets done," and I really do believe that that is true. So, if we really want to move the needle on improving health care quality and access, the measures we select really are very important.

The Workgroup meetings serve not only as a review mechanism for measures currently included in the Core Set, but it's also an opportunity to identify and fill gaps and consider measures to strengthen the ability to measure outcomes of the health home work. Our work provides opportunities to ensure the high-quality care and also to really improve health outcomes in the areas that are addressed and the needs of individuals participating in and receiving care through health homes.

Our focus of course during this meeting includes consideration, review, and discussion of only one measure today and whether the measure reflects the population served in the health home program will really serve to drive improvement in outcomes and care delivery. We really think that the measure should be a good fit for the Core Set and reflect the care and services provided through the health home program from the perspective of program-level quality measurement and improvement. So, we really want to think through the priorities of the health home program, whether there's room for improvement in the measure that we're reviewing, whether it's actionable and if it's technically feasible, and whether there's a good data source. With that, I think I'm going to go ahead and turn it over to Fran.

Thanks, Kim.

Thanks, everyone, for joining. To Margo's point, this is a significant use of everyone's time and, again, appreciate everyone joining and providing their feedback and important experiences. Just to reiterate what Kim said regarding the importance of this work, there are many different flavors of health homes across the country, which is fabulous, which makes our task here even more challenging but really gives us the opportunity to think through how we can leverage and support our Medicaid members and providers to achieve the best health goals that they set for themselves. So, we want to focus specifically about perhaps other data sources, if we can get clinical data, to also look at how the health homes are doing, as well as how the program is doing overall, as well as how the members are doing specifically. So again, it would be great to talk about that.

Here in Maine, we have a very good, very robust health information exchange. I know that's not true in every state, so that could be perhaps a limitation but would like to open it up during our discussion to talk about additional data sources and not just claims. Sorry about that text and to that point, I will turn it back to Margo.

Thank you, Fran and Kim for those remarks – really appreciate that.

Next slide, please.

Now we're going to introduce the Workgroup members and any disclosure of interest they may have.

Next slide.

To ensure the integrity of the review process, we asked all Workgroup members to submit a form that discloses any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest, or the appearance of a conflict, related to both the current Health Home Core Set measures or the new measure that will be reviewed by the Workgroup today. So, during introductions, members are asked to disclose any interests related to the measures that will be reviewed by the Workgroup.

Next slide, please.

When we go through the roll call, we ask that Workgroup members raise their hand when their name is called. We'll unmute you; and you can say hello, share any disclosures that you may have, or indicate that you have nothing to disclose. When you're done with your disclosure, please mute yourself in the platform and lower your hand. This will allow you to unmute yourself when you would like to speak during the discussion. If you've also muted yourself on your headset or phone, please remember to unmute your own line to avoid the dreaded double mute.

If you have any technical issues, please use the Q&A function for assistance. If you leave and reenter the platform or find you've been muted by the host due to background noise, just raise your hand and we'll unmute you.

Next slide.

With that, I'd like to proceed with the roll call. So here we have listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand. We'll unmute your lines, and you can indicate whether you are here and whether you have anything to disclose.

Fran starting with you, please indicate whether you have a disclosure.

I do not have a disclosure.

Great.

Kim Elliott?

Kim Elliott here, nothing to disclose.

Carrie Amero?

[No response]

Carrie, I think you're muted.

Can you hear me?

Yes, we can.

Oh, great, okay. Hi, everybody. No, I don't have a disclosure.

Thank you for joining.

David Basel?

Good morning. Dave Basel, nothing to disclose.

Thank you.

Dee Brown?

Good morning. It's Dee Brown. Nothing to disclose.

Jim Bush?

I did not see Jim. We'll keep an eye open for him.

Karolina Craft? Karolina? Karolina, you should be unmuted. Karolina, are you there? Are you able to speak?

It looks like her audio connection is not on.

Well, we'll come back to Karolina. I see her, but she may have dropped off of audio. Thank you.

Amy Houtrow?

Hello, everyone. My name is Amy Houtrow, and I have nothing to disclose.

Thank you.

Next slide.

Yes, Pamela Lester.

Hello, my name is Pam Lester; and I have nothing to disclose.

Libby Nichols?

Hi, I'm Libby Nichols; and I have nothing to disclose.

Linette Scott?

Hello, I'm Linette Scott. I have nothing to disclose, thank you.

Sara Toomey?

Hi, I'm Sara Toomey; and I have nothing to disclose.

Laura Vegas?

Hi, I'm Laura Vegas; and I have nothing to disclose, thank you.

Great, thank you.

David and Libby, could you please lower your hand unless you have something to say. Great, thank you.

Karolina, are we able to hear you now?

Hey, Margo I'm not sure if you can hear me. I will try.

Now we can.

Oh, now you can, perfect!

We can. Do you have anything to disclose?

I have nothing to disclose.

Great, thank you. I apologize for those whose names I mispronounced.

So welcome, everyone. It's great to have you here.

Let's continue on to the next slide.

We're also joined by federal liaisons, who are non-voting members. I'll read the name of the agencies but not do an individual roll call. We have the Administration for Community Living, DHHS, the Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality, CCSQ in CMS, the Department of Veteran Affairs, the Health Resources and Services Administration, the Office of Minority Health and the Substance Abuse and Mental Health Services Administration. So welcome to the federal liaisons. Federal liaisons, if you have questions or contributions during the Workgroup discussion, just raise your hand; and we'll unmute you.

I also would like to take the opportunity to thank our colleagues in the Division of Elderly Health Programs Group, or DEHPG and the Division of Quality and Health Outcomes, or DQ in the Center for Medicaid and CHIP Services. And also the measure steward of the measure under consideration, who is attending and available to answer questions about the measure.

At this time, I'd like to give Sara Rhoades from DEHPG an opportunity to provide welcoming remarks.

Hi, can everyone hear me?

We can, Sara thank you.

Great!

Hi, this is Sara Rhoades; and I'm the Technical Director for Health Homes. I just want to say welcome and thank you all so much for taking some time out of your day and throughout the year to be part of these meetings for us. It's very, very helpful.

I just want to let everyone know that this meeting, since there is only one measure that has been suggested, we still see this as a very important opportunity for Workgroup

members to help us strengthen state Health Home Core Set reporting. We're kind of going through a lot of changes with a new system and different ways that we're looking at some of the data products, so this is a really good opportunity to kind of be on the forefront of all of that in suggestions that you may have for CMS.

As part of that, as most of you are aware, CMS has a very high priority right now for health equity. So part of this discussion is ways that we could possibly stratify some of these measures and just encouraging that stratification of measures at a state level, and at a program level. So to advance health equity, which is so important and such a high priority of CMS right now.

Finally, I do want to just mention not part of this Workgroup but I know some people on the call are probably aware – and just to make everyone aware – that we do have a new health home optional benefit that is scheduled to come out October 1st. You may have heard of it referred to as ACE Kids, or Medically Complex Children, or there's a couple different names floating around there. But we refer to it internally as 1945A, which is the statute that it falls under, health home options. Though it's not part of this year's voting or measures, eventually that will get voted on and this is just the measures for that. So I just want to make everyone aware that that is on the horizon to come out October 1st for that new health home optional benefit. It will have its own – well, we anticipate, let me rephrase that – we anticipate it having its own Core Set of measures. With that said, thank you all again for being part of this Workgroup.

Thank you so much Sara, and thanks for all your support.

Let's go to the next slide.

At this time, I'd like to pass it over to my colleague, Jeral Self, who will be presenting some background and content for today's discussion.

Thanks, Margo.

Next slide, please.

The background on the next few slides you all may be familiar with, but we wanted to share some of this basic information about the Medicaid health home Program with all of the Workgroup members and public attendees.

The Affordable Care Act authorized the Medicaid health home state plan option to provide comprehensive care coordination to Medicaid beneficiaries with complex needs. Health home programs are intended to integrate physical and behavioral health along with long-term services and supports.

States interested in implementing a health home program must submit a state plan amendment, or SPA, to CMS. States are able to target Medicaid health home enrollment based on condition and geography but cannot limit enrollment by age, delivery system, or dual eligibility status. Each health home program requires a separate SPA. You'll notice that throughout this presentation and in publicly-reported documents, we refer to health home program-level performance.

Next slide.

As you can see here, health home programs are targeted to beneficiaries diagnosed with two chronic conditions; those with one chronic condition and who are at risk for a second one; or those with a serious mental illness. Chronic conditions include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions, such as HIV or AIDS, may be considered by CMS for approval.

Beginning in October of 2022, Section 1945A of the Social Security Act authorizes a new type of health home for children with medically complex conditions known as ACE Kids. Please note, however, that the 2023 Health Home Core Set Review does not cover quality measures for the ACE Kids health home program.

Next slide.

CMS established the Health Home Core Set of Quality Measures in January of 2013 for the purpose of ongoing monitoring and evaluation across all health home programs. States reported Health Home Core Set measures for the first time for FFY 2013 and recently completed reporting for FFY 2020. Reporting for both FFY 2021 and FFY 2022 will begin in September and generally cover services delivered in calendar years 2020 and 2021, respectively.

As a condition of payment, health home providers are required to report quality measures to the state, and the states are expected to report program-level measures to CMS. States are expected to report all of the Health Home Core Set measures for each of their approved health home programs regardless of their focus area.

Next slide.

This slide contains the measures on the 2022 Medicaid Health Home Core Set. There are 13 measures, including 10 quality of care measures and 3 utilization measures. The table shows the data collection method for each measure, the age range for which each measure is specified, the focus area for the measure, and whether the measure is also included in the Child or Adult Core Sets.

Next slide.

This slide contains a map of the states with approved health home programs that were expected to report Health Home Core Set measures for FFY 2020. As of December 2021, 21 states have 37 approved health home programs. It's important to note that some states have multiple health home programs that target different populations.

Next slide.

CMS recently released performance and trending data for Health Home Core Set measures for FFY 2020. All 37 health home programs were expected to report Health Home Core Set measures for FFY 2020, and 34 health homes reported at least one measure. The other three health homes did not submit data in time to be included in

publicly-reported data. Health home programs reported a median of 9 of the 12 measures in the FFY 2020 Health Home Core Set. The number of measures reported increased or remained consistent for 24 of the 26 health home programs that reported for all three years from FFY 2018 to FFY 2020. Reporting also increased for all nine measures included in both the FFY 2018 and FFY 2020 Health Home Core Sets.

Next slide.

To help Workgroup members review the measure suggested for addition, we wanted to recap the criteria the Workgroup members should keep in mind. The three areas are minimum technical feasibility, actionability and strategic priority, and other considerations. These are the same criteria used in the review of measures for the Child and Adult Core Sets. As a reminder, a measure considered for the 2023 Health Home Core Set must meet minimum technical feasibility requirements.

Next slide.

Because the Workgroup will only be considering one measure for addition during today's meeting, I'll start by reviewing the criteria for addition. Starting with the minimum technical feasibility requirement, these requirements help ensure that if the measure is recommended for addition to the Health Home Core Set, states will be able to report on the measure for each of their approved health home programs.

First, a measure must have detailed specifications that enable production of the measure at the program level. It must have been tested in a state Medicaid or CHIP program and/or currently be in use by one or more Medicaid or CHIP agencies. It must have an available data source or validated survey that contains all required data elements needed to calculate the measure, including an identifier for Medicaid beneficiaries or the ability to link to an identifier. The measure needs to be calculated in a consistent manner across health home programs using the available data source.

Another criterion articulated by CMCS is that the measure include technical specifications, including code sets, that are provided free of charge for state use in the Health Home Core Set. The Mathematica team assessed the suggested measure for adherence to these minimum criteria and found that it had met these criteria.

Next, measures recommended for addition should be actionable and aligned with strategic priorities in the Medicaid health home program. More specifically, when taken together with other Core Set measures, the measure should be useful for estimating the overall national quality of health care and Medicaid health home programs. Additionally, the measure should allow for comparative analyses of racial, ethnic, and socioeconomic disparities. Second, the measure should address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs. Finally, the measure should be able to be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs. For example, is there room for improvement on the measure, and can state Medicaid programs or health home providers directly influence improvement on the measure?

Some other important considerations for recommending a measure for addition include whether the condition being measured is prevalent enough to ensure adequate denominators for individual health home programs and whether the measure is aligned with those used in other CMS programs, especially the Child and Adult Core Sets.

And finally, Workgroup members should consider whether all states will be able to produce the measure by the FFY 2024 reporting cycle, including for all Medicaid health home populations. Later during today's meeting, we'll discuss opportunities for technical assistance to help states report the Health Home Core Set measures on this timeline.

Next slide.

This slide presents the criteria for recommending measures for removal from the Health Home Core Set. These criteria were provided to Workgroup members during the Call for Measures. Workgroup members did not suggest any measures for removal for this year's review.

Next slide.

This slide probably looks familiar to you by now. It provides a framework for assessing measures during the discussion and voting. The Workgroup should seek to optimize the desirability, feasibility, and viability of measures by recommending measures for addition that are desirable; that is, they are actionable and aligned with strategic priorities and that are feasible and viable for states to implement.

Next slide.

This graphic is a visual representation of the concept of multi-level alignment of quality measures. At the bottom, we have measures at the clinician or practice level which feed into measures at the program, health plan, health system, or community level. Health Home Core Set measures are considered program-level measures because they are for distinct subpopulations within the state's Medicaid program. The Child and Adult Core Set measures are considered state-level measures because they are intended to capture all Medicaid and CHIP beneficiaries within the state.

State-level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP programs as a whole. CMS values alignment of quality measures across programs and levels because it can help drive quality improvement by addressing each level of care so that improvement at one level may lead to improvement at other levels. Moreover, alignment is intended to streamline data collection and reporting burden.

Next slide.

This year, one measure was suggested for addition to the 2023 Health Home Core Set. That measure is listed on this slide and will be discussed and voted on during the voting meeting. The slide includes the measure steward, NQF number, the data collection method, age ranges, and an indicator of whether the measure is also in the Child or Adult Core Sets.

The measure suggested for addition is "Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions." This is an NCQA measure, and it has not been endorsed by NQF. While it includes individuals ages 18 and older, the measure has only been specified for use in the Medicare program.

Next slide.

Now I'd like to hand it back to Margo. Margo?

Thank you.

First of all, I'd like to acknowledge that Dr. Bush has joined. Would you like to introduce yourself and also indicate whether you have a disclosure? You may need to raise your hand.

Derek, please unmute Jim Bush.

Can you hear me?

We can, thank you.

Okay, yes, hi, sorry I was a little late. Jim Bush, I am Wyoming's Medicaid medical director, and I have no conflicts of interest.

Great, thank you so much.

Thank you.

Before we proceed with reviewing and voting on the measure suggested for addition, we'd like to pause to see if there are any Workgroup questions about the background and context that was just presented. Remember, if you'd like to speak, please raise your hand and I'll call on you in turn.

Fran, I see you have your hand raised. Is that because you have something you want to say or because it's left over from before?

Oh, sorry, I think that's left over from before. I'll try and un-raise it, sorry about that.

Thank you, no problem.

All right, any other questions or comments about the material you've just heard?

All right, it looks like we have no questions or comments at this point.

Let's turn to the next slide.

Now we'd like to spend some time discussing the voting process that the Workgroup will use.

Next slide.

Voting will take place after Workgroup discussion and public comment about the measure. Workgroup members will vote on the measure in its specified form. For the measure suggested for addition, a "Yes" vote means, "I recommend adding the measure to the Health Home Core Set." A "No" vote means, "I do not recommend adding the measure to the Health Home Core Set." For a measure to be recommended for addition to Health Home Core Set, the "Yes" vote needs to receive two-thirds of the eligible votes.

Next slide.

We sent a Voting Guide to Workgroup members last week and at this point wanted to pause to see if there are any questions from Workgroup members about the voting process before we have a couple of practice votes. Any questions from Workgroup members?

All right, let’s go on to the next slide.

As a reminder to all attendees, voting will be for Workgroup members only.

Workgroup members, please make sure you are logged in to your voting account and have navigated to the Core Set Review Voting page. If you need any help, please refer to the Voting Guide or send us a message through the Q&A. And also if for any reason you are unable to submit your vote, please send us your vote through Q&A. Your vote will be visible only to the Mathematica team monitoring the Q&A.

Now I'd like to ask my colleague Erin Reynolds to take us through the practice voting. We'll do two different practice votes to make sure everyone can access the voting platform and cast their vote.

Next slide.

Should we be seeing this request on our Poll Everywhere?

Yes, you should. I apologize. My audio did cut out for a minute, so I am not sure where I left off; but voting is now open. It looks like we have some raised hands here.

Dee Brown, do you have a question?

I do because I cannot find my Poll Everywhere e-mail. I had sent an e-mail asking about it, and I did not receive it. I don't know if it got blocked.

I did not receive one either.

Okay, so I'm wondering…Tricia is going to send an e-mail again to Workgroup members. This is why we do practice voting; so hopefully you will get it this time, and it will have a link.

All right, Jim, you have a question?

I was just saying I had not received a link to vote either.

Okay and Karolina same thing?

Actually, so I am in the app, but the questions that I see is, "Do you prefer the beach over the mountains?"

What is the question that you see?

"Do you prefer the beach over the mountains?"

Oh my goodness, I think you'll have to refresh. That's a pretty old question. So are you able to refresh? It should say "pizza" rather than "beach."

Let me see.

Margo this is Linette. I'm in, and I see my response history from the last Core Set meeting; but it's not showing this question. Normally it pops up, but it's not doing that.

So is there somebody else who might be able to help troubleshoot?

I think you need to refresh.

I've done that.

Okay.

Maybe if someone on your side can resend the question? I don't know.

I think that would be a problem if we resend the question because we already have four results.

This is Libby. I had the same issue; and instead of refreshing, I pressed the “home button” and then entirely relogged in using the Core Set Review name. But I had to like relog in to get it to refresh to "pizza" rather than "mountains." I'm not sure if that's helpful.

Okay, I'll try that, thanks.

Everyone, feel free to unmute yourself and just speak. I see we have a lot of hands raised.

I didn't get it either, the whole thing. I'm not at the beach or eating pizza. Both sound great, sorry.

Okay, so Tricia just resent the guide and link, so hopefully it’s not too much trouble, hopefully you can go check your e-mail. This is why we allow plenty of time for practice voting.

We do have four people who were able to vote.

Hi, this is Carrie. I still haven't seen that e-mail if it was just sent. I don't think I got it before either.

I still have not seen an e-mail yet either.

I have not seen it either.

I wonder if it's getting blocked. Tricia, did you send it through the TA mailbox or from your personal e-mail.

I sent it from my personal e-mail [redacted]. I got automatic replies from Sara and Carrie. Let me try sending it to you again.

Oh, and I just got it. This is Carrie. Thank you.

Okay, great.

This is Sara. I got the e-mail, but it's not letting me. I put in my e-mail address and then the password that's on the PDF, and it's not letting me in.

So the other part that I forgot to do was that once you log in, then you have to join the presentation; and then it popped up.

Yes, so once you log in, do be sure to try joining the Core Set Review presentation, which was the link in the e-mail we just sent. I think the best way to test it is to just answer the text question that should be up there about thin crust pizza, and we'll monitor who's able to vote and who's still having challenges.

This is Fran. I'm trying to log in. Is it a personal password, or is it a Mathematica-delivered password?

It is a password that we delivered to you in the e-mail.

My apologies, it's Dee Brown. Still I have not gotten the e-mail.

Dee is the best e-mail for you still [redacted]?

Yes.

All right, I'm going to try sending it to you again.

This is Sara. I'm getting an error that's saying new registration is required, but I registered before.

So try logging in.

It won't let me. It says that my password and username isn't correct.

Okay.

We have 11 people that have voted out of 13, so we're getting close.

I'm wondering if, I'm happy to just put it in the Q&A? Is that what was easiest for everybody?

That's what I was going to suggest at this point, and then we can keep trying to troubleshoot. But if we have 11, that's good for this test. Why don't we send it to the Q&A, and then our team will input the results on your behalf.

Great, anybody in particular or just all of it?

I think you can do it to the Q&A. That does go to the Mathematica team, to "All Panelists," yes. I think, Dee and Sara those are the two that we're missing – Sara Toomey and Dee Brown.

Yep, I just sent it.

Excellent.

In the Q&A? Because I can't see the Q&A on the meeting.

Do you see it at the bottom right?

No, I do not see it.

Do you see an ellipsis option?

Yes.

Click on that and see if Q&A is an option.

Got it. I see it, but I don't have anything in Q&A.

Can you submit a question via the Q&A?

I sure will.

Okay, and then you can just submit your vote that way, thank you.

Okay, we're getting close.

Okay, do we have the two responses in; or should we just do the results now on pizza? And then we'll move on to the next vote, which is about salad.

Erin, why don't you display the results on pizza. Okay, so you can see that 73% voted, "Yes, I prefer thin crust pizza." If this were a vote about a measure, it would have met the two-thirds threshold; and it would have been recommended by the Workgroup for thin crust pizza.

So thank you, Erin. Let's move on to the next practice vote and see how we do with that one. Okay, so this one, "Would you choose a Caesar salad over a Greek salad with your pizza?" The answer choices are, "Yes, I would choose the Caesar salad," and "No, I prefer the Greek salad.

Voting is now open. I see we're already up to 10, superfast. We're still waiting for, I believe, three more responses.

Okay, we're up to 11...waiting for two more. If it's not working to get into the polling system, then just send your response through the Q&A. Oh, we're up to 12.

Are we missing one more? Are we able to put in that 13th vote? We are up to 13. Okay, we are all good. So voting is closed and let's see the results.

Okay, so with this one, 62% said, "Yes, I choose the Caesar salad." So if this were a measure, it would not be recommended because it does not meet the two-thirds threshold.

Thank you, everyone, for testing out the polling. I know it took a little bit of time, and we're still working out some kinks; but I think we're doing great. So when it comes time to do that one vote, I have a feeling it will go pretty quickly.

With that, let's move on to the next slide.

Great, so now we're going to discuss the measure that was suggested for addition to the 2023 Health Home Core Set. We will present the measure briefly and then open it up for Workgroup discussion about the measure. After the Workgroup has discussed the measure, we'll have an opportunity for public comment, and then proceed to Workgroup voting on the measure.

Next slide.

Okay, as Jeral mentioned earlier, the measure suggested for addition is "Follow-up After Emergency Department Visits for Individuals with Multiple Chronic Conditions." The measure captures the percentage of emergency department visits for members 18 years and older who have multiple high-risk chronic conditions, who had a follow-up service within seven days after the ED visit. This is an NCQA measure, and the measure is not NQF-endorsed. The data collection method is administrative, and it is calculated using claims and encounter data. The measure is not on the Child or Adult Core Set, but it is part of the Medicare Advantage Quality Improvement Program. The measure would align with the “chronic conditions” health home focus area.

Next slide, please.

This slide contains information about the denominator for the measure. Like other follow-up measures on the Health Home Core Set, the measure's denominator is based on ED visits not members. Eligible ED visits are identified where the member had two or more different chronic conditions prior to the ED visit. The slide lists the eligible chronic condition diagnoses that are included in the measure specification. I'll pause for a second so people can take a look at that and how they align with your health home program.

All right, next slide.

This slide contains information about the numerator for this measure, including the type of follow-up services that are numerator-compliant. As you can see, the follow-up service must occur within seven days after the ED visit, or eight total days. The

measure includes quite a wide range of eligible follow-up visits, as listed on this slide – multiple settings and modes of visits.

All right, next slide, please.

Now we'd like to open it up for comments and questions from Workgroup members on the measure. You may unmute your line if you wish to speak. Please remember to state your name before making your comment.

Hi, this is Fran Jensen. Have we received any feedback from the Medicare Advantage participants who are collecting and reporting on this measure in terms of is it easy to get, what do they think, is it a useful measure?

That's a great question. We have not.

I'm wondering, Kim Elliott, if you have any insight as part of the work that you do at HSAG?

Kim, you are muted. You can unmute yourself. There you go.

Sorry about that. Yes, it is a measure that is brought up in discussion when we talk performance measure validation with many of the states that we work with. The challenge always comes in because it is a Medicare measure versus a Medicaid measure. So, it becomes a little bit more challenging for our states to want to move forward with, but it is something that is of interest to some of our states.

And I think if it was adopted for the Medicaid program, if NCQA had moved in that direction, I think that it probably would have been picked up because it really does impact multiple different areas that states focus on chronic illness, emergency department utilization, follow-up care and services, which is a measure that they use for other types of services, such as behavioral health inpatient and ED visits. But it is a little bit more challenging for them because of it being specified as a Medicare measure.

But the populations that would be included do impact Medicaid. The chronic condition states of course impact all populations. Because it's an easy measure to collect administratively, I think that it would be a very reasonable measure for Medicaid programs to utilize if it were included in a Core Set.

This is Fran again.

Thanks for that, Kim. I'm always thinking about burden, so that's the context for my question. I agree though, in terms of I can just say from the health home perspective, it seems like it's all about chronic conditions and supporting getting those folks the care they need. So it makes sense. It also aligns really nicely with some of the measures we have regarding total cost of care, right? Because ED utilization is a large piece of that. So assuming we can work out all the technicalities, it seems like a good measure. That's just my first thought. I'm sure I'll have more though because I always do.

Thanks.

This is Dee Brown. Kim, I understand the thought process there and thinking that lots of them might want to include it; and it certainly does fit well with what health homes do. But I have a question, I guess, about the measure review worksheet – that the minimum technical feasibility is that at least one state had to have -- the measure must have been tested. It says, "must," not "may have been." It must have been tested in state Medicaid and/or CHIP programs or being used by one or more Medicaid and/or CHIP agencies. And this one is not, so is that a disqualifier? That's my question about the minimum technical feasibility requirement.

It's a great question. I actually thought about that this morning as well. I think what we found is that – and this is partly what I think Kim was alluding to – is that a number of states have explored using it and then ended up not actually adopting it. For example, looking at it for a quality strategy in their managed care program. So I think we decided to include it this year because of the interest in it and its applicability and the fact that several states have actually considered using it, even though they may not be actively using it. And so we did bring it to the Workgroup for consideration.

It is something that the Workgroup could also, as part of this conversation, have a reflection when we start talking about gaps or when we start leading up toward the voting of saying that, well, this may not be ready for prime time, but we're very interested in this measure. We think that it's worthy of further measure testing/measure consideration by Medicaid health home programs or perhaps Medicaid more generally.

So I think, Dee, you actually kind of – you framed something that has been on my mind as a direction that this conversation could take as an alternative to voting to recommend it for the Medicaid Health Home Core Set for 2023, but having a conversation about how it might fill a gap if there were further evidence. And the way I thought about this lately is in terms of thinking about the criteria. So thank you again for referring back to our criteria. We have strategic priority and actionability as a criterion, along with minimum technical feasibility criteria. So I think the Workgroup could say, you know, if this is really a strategic priority, it's actionable. I like, again, the way you framed it, Fran in terms of total cost of care -- that that fits into something that we're really focused on, but it's not necessarily ready for the Health Home Core Set at this point because of the conversation that we've been having up till now.

So I don't want to put, you know, a kind of bias to this conversation, but also reflect that there are other options potentially to consider given what everybody has been raising in terms of whether it is necessarily ready for the Health Home Core Set. But maybe it is a strategic priority and an actionable measure, just not maybe for 2023. Does that resonate with you, Dee, as another way to think about this?

It does. I didn't see in the write-up – and I apologize, I didn't research this. This is my second question. Is this already on the Adult Core Set today?

No, it is not. It is not on the Adult Core Set. We do have other follow up after ED measures -- Follow Up After Emergency Department Visit for Alcohol and other Drug Abuse or Dependence and After Emergency Department Visit for Mental Illness, but not this one.

This is Sara Toomey. I just have a question for clarification. It looks like sort of like the Venn diagram of conditions between like the populations served by the Medicaid health homes and those that are included in the context of the proposed measure don't completely overlap. Is the thought process that this then – that a program could choose to use this measure for the subset of patients for which they have one of those conditions; or would the notion be, there might need to be – this used for conditions that this hasn't been validated for by NCQA?

That's a great question. So the measure under consideration, and all measures that are considered for the Core Sets, are to be considered as specified. So if you were to implement this in your health home program, you would be implementing it for the diagnoses in the denominator and the types of visits in the numerator in the follow-up visits. So it would need to be implemented as specified, so you probably have some health home members/enrollees that would not fit into that denominator because they have other conditions, or you might not have some of those conditions included in your health home. So again, those might not be applicable. But the idea would be that if this measure were adopted, it would be calculated as specified based on the chronic conditions in the measure.

Thank you.

Hi, this is Dave Basel and I've got a couple comments. One is kind of more of the technical side of things. I would certainly be more comfortable if this had been tried out by a state before going into this because I do think there's going to be some, with this being a Medicare measure, there can be Medicaid-specific technical details to get worked through. I'd rather see that be successfully worked through in a state or two before we take it broadly. Such as the numerator has telephone visits. Well, how many Medicaid administrative entities can get the telephone service to be able to report on that? So there's some aspects of that that I think are going to have to be thought through.

Then the other, more general, concern that I have at this point is one that I'll probably raise at every single meeting that you invite me to attend – is that we're adding something that has some considerable overlap with those other two measures on the Adult Core Set and ED Follow Up After Substance Use and After Mental Illness Visits. So this is going to be kind of a muddy measure overlapping with those two and potentially diluting out those two. So in general, if everything's a priority then nothing's a priority. So generally if we're adding one, I want to see one deleted at the same time.

So if we were talking about maybe substituting this measure as more all-encompassing and getting rid of the depression-specific and mental health-specific measures, then I could see that. Or if we think that mental health and depression are the focus, then let's leave those and not add this one. So the overlap there concerns me.

That's a great point.

Linette, do you have a comment?

I was just going to echo. I think this kind of got talked about, but the question about the alignment of the chronic conditions that are in the measure and the chronic conditions that are in the health home program -- so the fact that they're not, you know, entirely aligned. I think that kind of piggybacks on some of the comments that people have made about the Medicare versus Medicaid because we do see some differences in terms of what we can measure given some of the conditions tend to be more prevalent in folks that are 65 and older. And then how does that play out in terms of our ability to do the data if we don't necessarily have the Medicare data to include in the measure when Medicaid is the secondary payer?

So kind of echoing some of the other comments that folks have made about understanding how the measure works in the Medicaid population given those kinds of issues, and then we do have other follow up after ED visits specifically already in the measure set. So echoing what's been said before, but thank you.

That's really helpful, thank you.

Carrie?

Yeah, I have some questions and comments, I guess, about how the numerator and denominator would be calculated. One is, would the ED visit have to be related to one of those chronic conditions? I mean, I assume the idea is that we would want to see more people having a follow up within seven days; but what if they're in the emergency room because they broke their toe, and there's no follow up related to their chronic conditions needed; or the guidance is, "See your general practitioner next month"?

The guidance isn't that you need to see anybody in the next week. Does that get factored into the numerator? Is it all-cause ED visits, or is it specifically related to the chronic conditions? That's a question, and then I have another couple comments.

Yeah, I'm wondering if we have anybody from NCQA that's been able to join from the measure steward? If you could raise your hand if you're here, we will unmute you. Is there anyone from NCQA? I don't see Alyssa Hart or Sepheen. We're thinking we might not have had anyone from NCQA join us at this point.

Hi, I'm definitely not from NCQA; but I similarly had kind of questions around the nitty gritty of the measure, especially just sort of with the concerns around it being specified for a Medicare population very clearly. It looks like from my review of the specifications, so with a small grain of salt, but it looks like the ED visits do exclude ones that turn into an acute or non-acute inpatient care stay. But also, I think that there are some exclusions around something like a toe injury or something.

But it does look like also some of the outpatient visits following that are eligible for the follow up are a little bit more varied. One of the things that I really flagged when looking at the specs was that also to get those eligible chronic conditions – so to get the eligible population, it requires a 365-day lookback before the ED visit so that you can identify those chronic conditions prior to the ED visit, which while it sounds feasible I do think is a little bit maybe more complicated for a Medicaid population than a Medicare

population – so just something to consider. There are some exclusions for the ED visits that are like related to the denominator, but it's a lengthy spec. I don't have it memorized, but—

But it would [multiple voices] on things that are not related to the chronic conditions.

Yes.

Okay, so then I'm also just wondering about the definitions of what the follow up could be. There's a lot of different options. Sometimes the guidance is you need to make an appointment with your physician, and so the patient would do that. But they can't get an appointment for 10 days, so would you still count – like if the hospital called or the case manager or somebody called and said, "Have you been able to see your doctor?" and the person said, "No, but I have an appointment next Tuesday," does that count as an e-visit or a telehealth visit, just the check to see whether you have an appointment? Or would it actually have to be a service that's billable in order for it to count as the service happening within seven days?

Yeah, that's a great question. My impression – because this is claims and encounter-based, so an administrative measure – is that you would need to see evidence of the visit in a billed claim.

Based on what I was reading in the specs, I concur. Also, there are some care management services that can be billed related to it; but I think those still have to be – the date billed on that care management service, even though it might be kind of per month, would have to be within the seven days, and it would have to be all billable services.

So I guess I'm just wondering then if there's some percentage that anyone has identified as being the desirable percentage. I mean, presumably there would be some situations where there's a perfectly good and valid clinical reason for there not to be a follow up within seven days. Is there some estimation of how many visits fall in that category? It there a target, or is the idea that this should try to get as close to 100% as possible?

That's a great question. I don't think we have any benchmarks or any evidence of what an ideal rate is other than perhaps higher rates are better.

Is there data to show that having a visit of some sort improves outcomes? Presumably there is, but I don't know.

That's a great question. This is Laura. That would be my question.

Sorry, I didn't mean to usurp your thunder.

No, that's great, thank you.

Kim, it looks like you have your hand raised. Did you have a comment about that?

Did you say Kim or Carrie?

Oh, I said Kim Elliott. Do you have your hand raised?

I do. Well, I was looking at the exclusions; and the only exclusion is for hospice or members that were enrolled in hospice. To be eligible for the denominator, you do need to have two of those chronic conditions that are listed in the value set. So if you don't have two of those conditions, you would not fall into the denominator; so you would not be included or measured for the numerator.

Carrie did that answer your question; or do you have any other questions or comments at this point?

Yeah, I think that helps. So you would have to have two to get into the denominator, and then, so it wouldn't necessarily be all-cause, it would be all-cause except for hospice or if there was an inpatient or something.

Correct.

And given the expense—

I was just going to say so if your program doesn't include one of those conditions and that was one of the chronic conditions that qualified for the two chronic conditions, they would not fall into that denominator.

Why don't we move on to Amy. Did you have a comment?

Yes. Hi, everyone, this is Amy Houtrow. I do have a question that we're talking about, and it's relevant to the different chronic condition list. Perhaps this is a really ridiculous technical question; but what it says is "eligible chronic condition diagnoses are as follows; each bullet indicates an eligible chronic condition." And then it contains more than one in each bullet. So for example, COPD and asthma. I'm unclear if that means that they must have both COPD and asthma to meet that chronic condition. The same thing would be true of stroke and a transient ischemic attack, and then also Alzheimer's disease and related disorders. So I'm wondering why it's written that way and why those don't have their own "and/or" or separate bullet points.

That's a good question.

Do you want me to answer that question? I know NCQA, is not on the line, but I do audits for NCQA. So those are grouped by types of respiratory conditions, et cetera, in the value set, so each of those would be separate diagnoses in the value set. Does that help answer that question?

You said "each of those" in the value set. Let's take specifically COPD and asthma. So those are different conditions. So are those two conditions, or do you have to achieve both conditions to meet that? Because that's how it's written right now.

Yeah, it's not an "and." They are grouping the value set codes by including all COPD and asthma codes in that value set. And in order for it to meet, it has to hit a code in that value set.

Gotcha, thank you.

This is Libby, but one other caveat. If someone had like COPD and asthma, that would not count as their two chronic conditions. That would still only count as one contributing chronic condition. So then they would need something from another bullet area to get—

Oh, thank you, that's helpful.

So the "and" means any of these things are part of this value set bundle, but you need something from multiple value set bundles.

And thank you for pointing out and making that clarification. I think the reason why it's specified this way on the slide is because it's showing in effect two value sets, a COPD value set and an asthma value set. So it has to hit one diagnosis in one of those value sets. So thank you for pointing that out as a clarification, that could be very confusing of how this is specified.

The clinical person that deals with these things, these conditions, it may be helpful to do it by system with bullet points. So you'd say respiratory conditions – one bullet, COPD; one bullet, asthma.

And I don't know what "Alzheimer's diseases and related disorders" means, but I assume that's specified much clearly – but agreed, it would absolutely need to be clarified.

This is Kim. It does actually clarify that. It says in the measure specifications in parenthesis, "for example, COPD and asthma are considered the same chronic condition." It's because it's grouped as a value set.

Yeah, it's just not the way we think of it. Do you know what I mean? Like *you* think of it that way, but clinical people don't think of it that way. So it's just weird. But as long as you, the measure wonks get it, that's cool too.

All right, Pam Lester? Oh, sorry.

Don't mean to call you – you know, I very much appreciate measure wonks. Don't take that as a negative, Kim.

But you're making a good point, Fran. And I think this whole conversation is pointing to the kind of two languages, one clinical and one technical specification. And what we've shared here is more kind of aligned with the technical specification language, that's what we're trying to present. You've pointed out and everyone here has made comments about how to interpret that, so that's very much appreciated.

Pam Lester?

Pam, can you unmute yourself?

Derek, can you unmute?

There we go, thank you. This is kind of a little bit of speculation but kind of how I think of these groups together that might be helpful for others. I'm a combination of clinical and measure. John Hopkins has EDCs, its condition categories and these fall in line with condition categories. When you think about risk of utilization, it's looking at the condition categories; and having two or more condition categories puts you kind of in a high-risk category for utilization, which would then make you at risk for higher ED visits. So in that, I think that's where it gets to the two. And I'm, again, speculating just from my past experience with using John Hopkins' EDCs as a risk of utilization measure or tool. So COPD and asthma is under one category, and Alzheimer's and related disorders is another category. So is stroke and TIAs. So when I'm thinking about this measure and how they're organized by bullets, it really aligns with that tool. So I don't know if that blubbering was helpful to any of you at all, but that's kind of how I was seeing that.

That's very helpful, thank you.

Dee Brown, do you have a comment?

Yeah, I have a question on if this was reviewed against the disease states that are listed in the chronic conditions composite. So if we could, if we accept this measure, is it correlated to these same conditions that we're measuring under the AHRQ chronic conditions composite; or is it not aligned?

That's an excellent question. I don't think we know the answer to that at this point. But I think going back to the point made earlier about potential opportunities for further assessment of the measures fit in the Core Set, that's certainly something that could be suggested for follow up – is to look at how that relates to – well, the measure you're referring to is PQI92, how that might be correlated. And in an interesting way, actually – both looking at potentially preventable events with good primary care, good care coordination. So a very good point as to what is the value add of this measure on top of PQI92.

Correct, because I always look at that measure as more outcome-related. And so I think Dr. Basel made a very good point when he said if we add one, do we take one if they're not correlated so that we could see -- somebody else mentioned the ability to impact on outcomes, right? So if they're aligned, then maybe that could show us that impact which would be a good thing. If they're not aligned, I'm not sure – so great comments and discussion on this measure.

Yeah, very – and I think it's very complicated because when you look at PQI92, some of the admission diagnoses – like diabetes, hypertension – could be related to some of these other chronic condition diagnoses in this measure; but they might be a different measure set yet still correlated. So I don't think we know the answer to that; and it's a really interesting question to think about, especially when you're thinking about trying to have a rather parsimonious measure set and then what's the value add of each one. So thank you for those comments.

Yes, and also overseeing the health home programs in multiple states because I am national, when I look at the problems or conditions for members going into health

homes – you just mentioned diabetes, but HIV is a big – if I look at the top three conditions, it's COPD, diabetes, and HIV for chronic conditions. That's the prevalence in all of the health home programs, so it's not – it's got the COPD, but it's saying "and asthma" as we talked about. Alzheimer's and related disorders are not typically but can be included in some health home programs. Renal failures, typically people end up in a health home program in some situations but typically don't. So, yeah, it's just a list of the conditions and how they correlate over to the other indicator that we have that I was curious about – so thank you.

Yeah, and thank you for that comment. I am noticing that we do have somebody on from NCQA now. Karen Onstad, are you able to raise your hand in case we have questions for you; and we can unmute you?

Derek, can you unmute Karen?

Karen, your line is unmuted.

Karen, we actually have had some questions for NCQA. I don't know if you're in a position to be able to answer them or to take them back at some point, but I did notice you had joined and wanted to acknowledge you. Are you able to answer questions about this measure?

Hi, can you hear me?

We can.

Sorry, I was having trouble unmuting. And I'm sorry, I did just join, so I am happy to take questions back, but I just joined in the last minute.

No problem, well, I'm glad I saw that you had joined. We do have some further questions and comments coming from Workgroup members which we'll take and also have a chance to surface back some of the questions.

Well, let me just ask you one question that has come up and that you might be able to answer or not. I think the big question is the applicability of this measure from – it's specified right now for Medicare, and of course we're talking about Medicaid health home programs. So there's been some interest in this measure within Medicaid; but because it's not specified, it's reminding me a little bit of Colorectal Cancer Screening, which was specified for Medicare but a lot of states had started using it because of its importance within the Medicaid population.

So are you familiar with any use of this measure in Medicaid, number one? Number two, any plans of NCQA to adopt this measure for Medicaid or what would be involved if a state Medicaid agency wanted to use this in its health home program? I guess that's one big bucket of questions about adapting this measure from Medicare to Medicaid.

Okay, I am not familiar, unfortunately, with use of the measure in Medicaid or adaptations for it. But I can get – I can poll internally and see what information we might be able to provide.

Okay, that would be great.

With that, let me go back to the list of hands that are raised. Jim Bush, if you have a comment or question you wanted to make?

There's been a lot of good points. I just know that based upon this, I think my data analytical people are going to pull their hair out given the complexity of it.

Jim, are you done? It sounds like you might have gotten cut off after you said your data analytics people would pull their hair out because of the complexity, or is that...?

It looks like Jim is re-muted. Why don't we move on to Karolina.

Hi, can you hear me?

We can.

Oh, good. So actually, I had very similar questions for NCQA that Margo you just asked, but I wanted to add just one more to the list. I was just curious why the measure was only specified for Medicare to start with. It also reminds me -- the discussion that we have right now reminds me of the Colorectal Cancer Screening discussion we had last year. I remember that there were reasons why it was only focused on Medicare to start with. And I was wondering if maybe there are technical reasons why NCQA did not consider Medicaid that we should be aware of.

Karen, is it possible for someone from NCQA to join right now? I know we've reached out to Sepheen, and I think Alyssa has been signed up. Why don't we move on and hopefully, Karen, you can identify somebody with an answer about the Medicare specification that can help the Workgroup.

Jim Bush, did you have anything else you wanted to say? I see your hand is still raised, and I think you got cut off.

Oh, I'm sorry, I should have lowered it again. No, I think this is a good discussion. But as you said earlier, I don't think this is ready for prime time in the Medicaid population. That's all.

Okay, that's very helpful, thank you.

I don't see any more hands raised. Oh, Libby, I saw yours go up.

Hi, yeah, I just sort of – and this is a little bit of echoing things that have been brought up, but I think one thing to consider is that a lot of these questions – especially around like moving, adjusting specifications when something is specified for Medicare and then changes and it's being used in the Medicaid population or whether the eligible chronic condition groups are targeted in a way that we would capture our target population – I think that a lot of those questions get ironed out a little bit better when the measure has been used in states and there's clear feedback about where it didn't work and how to resolve or improve that.

So I think I just sort of wanted to echo my concerns that it's not in the Adult or Child Core Set and is not necessarily used by any state Medicaid program at the moment that we know of. So there hasn't really – we don't necessarily have a really clear view of where there might be places where the codes need to be adjusted or something. It just hasn't had an opportunity to be ironed out, and so then ironing that – but like then putting the priority for the health homes to iron that out when it's not being for the Adult and Child Core Set can be tough when the states have limited resources and there's only so many measures to focus on and this one's only in the health homes. I think that can be a little bit tough to then go about resolving those issues when it's only pertinent to a small population, or a smaller population. So I just sort of wanted to echo comments and concerns, and I think that was it. Reviewing my notes, I think that was it.

Those are great comments, thank you. And kind of the whole idea of the Child and Adult Core Sets almost being a training ground before it enters the Health Home Core Set, that's a really good point. And then the point made earlier about what's the value add beyond the FUA and FUM measures and also how does it correlate with PQI92 – I think those are all really good questions that have been raised that we don't have the answers to at this point, but thank you all for raising those.

Any other comments before we open it up for public comment?

Yes, this is Dee Brown. I did look up for the PQI92, and let me just read to you the diagnostic list. It's pretty short: Diabetes Short-Term Complications Admission, Diabetes Long-Term Complications Admission, COPD or Asthma...not and...in Older Adults Admission, Hypertension Admission, Heart Failure Admission, Angina without Procedure Admission, Uncontrolled Diabetes Admission, Asthma in Younger Adults Admission, Lower-Extremity Amputations amongst Patients with Diabetes.

So to my other comment about the top prevalence conditions that I see across the United States in multiple state programs for health homes, diabetes is all over this one; and it's not in the other measure.

Great, thank you, that's very helpful. Other comments before we open it up for public comment?

Well, thank you, Workgroup members, for a very robust conversation. This is really helpful.

All right, next slide.

Now we will open it up for public comment. As a reminder, please raise your hand if you wish to speak; and then we will unmute you. Do we have any public comment?

Last call for public comment.

All right, I'm not seeing any public comments, so why don't we move on to the next slide.

Now we're going to vote on the measure. Everybody get ready for voting. So this is the vote that we're going to take at this meeting. The question is: "Should the Follow Up After Emergency Department Visits for Individuals with Multiple Chronic Conditions measure be added to the Health Home Core Set?" The options are, "Yes, I recommend adding this measure to the 2023 Health Home Core Set," or "No, I do not recommend adding this measure to the 2023 Health Home Core Set." Voting is now open.

Look at this. We've already gotten ten results, so we're waiting for three more...two more. If you're unable to submit your vote, please put it into the Q&A to "All Panelists."

I'll do that. This is Fran.

Okay.

All right, we're up to 12. We are waiting for one more.

Fran did you say you were sending your vote via Q&A?

Yeah, I'm in the Q&A now. I wrote in my answer, and it won't let me send it.

Hmm.

Can I send an e-mail or put it in the chat or something?

Well, there is no chat; so it would have to go through Q&A. We prefer that.

This is weird.

Actually, you're seeing chat?

So I am seeing chat.

Okay, well then maybe you can as a panelist. So why don't you try the chat, except make sure you just do it to "Panelists." Otherwise, everybody will know how you voted.

Okay.

Or you can send it via e-mail to Tricia.

I'll just send it via e-mail because it's not working.

Okay.

Thanks, everyone, for your patience.

Sorry, everybody.

Fran you might be able to send it through the chat now. Derek enabled it for you.

Send it to the “Host”?

Sure.

Okay.

Again, apologize, everybody. I don't know what happened. It worked before.

Okay, so we should be ready momentarily.

Okay, we are ready so now for the results. Okay, 15% of Workgroup members voted "Yes," and that does not meet the threshold for recommendation. The "Follow up After Emergency Department Visits for Individuals with Multiple Chronic Conditions" measure is not recommended by the Workgroup for addition to the 2023 Health Home Core Set.

Thank you, Workgroup members.

Let's move on to the next slide.

So now we wanted to open the floor for a discussion of potential measure gaps in the Health Home Core Set. This can be measure concepts that may be missing, potential gaps related to care coordination, social determinants of health, any other gaps that you see. We wanted to open this up to Workgroup members. Who wants to go first?

Now we're going to a bigger picture conversation about gaps after we've just talked about one measure in great depth. So thinking back, would it be helpful to move back to the measure list for everyone to look at?

This is Dee Brown. My hand is not working. I don’t think you can – I can't see me on the list; and every time I raise my hand, it's not working.

I can see you.

Okay, so the only thing that I think – as multiple states across the country, whether they have a health home program or not, are very focused on integrated care medical and behavioral health. We all know that many of our members who are in a health home program have both conditions. And so there is a lot of CoCM [Coordination of Care Models] work being done in Medicaid state programs, where there's a billable possibility to say that we had a behavioral health service conducted in a primary care practice – so talking about integrated medical and behavioral health services. I'm curious what other folks think about seeing if we can look next year how many states are actually allowing for that billing in the Medicaid programs and if there's enough where we have health home programs, would it make sense for us to start – it's an administrative claim that could be counted. I don't know if any of the measure stewards have considered looking at CoCM billing for a quality measure set to show integrated medical and behavioral health services. It's not today something that any of the measure stewards have considered, so more to the public group that's on the call – very curious about their thoughts about CoCM.

This is a good suggestion, Dee as we're thinking more broadly not just about existing measures that this group knows about but casting a wider net to think about potential measures or measure concepts. So thank you for raising that. Does anybody have a follow-on comment about that?

All right, other comments about gaps? We've put the measure list up on the screen so you can see this. David?

An obvious one to me that I'll probably get dirty looks from anybody that's actually having to submit information is the disparities piece of this is how do you divide these measures up to see – I guess our entire population in Medicaid is kind of a disparity population in and of itself but looking for subpopulations that are particularly hard hit. And that is something that would be a dream, but just the technical complexities of it are potentially overwhelming.

So this is something we want to talk about quite a bit after the break to really think through how one might stratify these measures. We're thinking about things like race, ethnicity, language, disability status, and then also geography – urban/rural – given a lot of focus on our rural health care as well. So I think we're very interested in hearing a lot more about that when we get to that this afternoon, although certainly happy to have people chime in about that at the moment.

But thanks for raising that.

One thing – that's a really good idea, and I'd be interested in talking about how to – a measure that focuses on folks with intellectual and developmental disabilities. We're trying to do that here in Maine, so looking forward to that discussion. But one thing I just have a little – have a – what's the right word – suggestion or a question about is, is there a way to change the title of the measure? Because we don't' use the term "abuse" anymore. We use "drug use," trying to get rid of that stigma. So this, I know, isn't the forum for this but just throwing it out there.

Well, we do still have somebody from NCQA here who will be hearing that comment that you've just made.

Okay.

I assume you're referring to the IET measure as well as the FUA measure, those are the two?

Yep.

So, Karen, if you want to take those comments back to NCQA, drug use or dependence, that's great.

Thanks, Fran.

Thank you.

Linette?

I guess just looking at the list of measures that we have, we've added some over time. I don't know that we've really taken very many off, so it's getting to be a fairly robust list. When you look at the measures, there's a focus on chronic conditions and on substance use disorders, mental illness, and such. The only real preventive measure, I think, is the

Colorectal Cancer Screening. So one of the things that I think we sometimes talk about when we think about folks that have more chronic conditions is: are they getting the preventive screenings that they need as well, or do we as a health system get focused on the chronic conditions and lose track of the preventive services?

So while there's more preventative services, I think, we track on the Child Set than the Adult Set, I guess that may be something maybe to think to in the future, is are there any other preventive measures that would make sense to add in to make sure that aspect of care is not getting lost in the context of more complex conditions – for lack of a better way of saying it. And in that context to perhaps look at the measures we have and is there any way to perhaps slim them down some – so kind of a remove one/add one kind of thought process.

Thanks, Linette that's great. I do have one thought that I want to pin for later on when we start talking about the use of alternate data sources because in theory, if we had a really good indicator of who's in a health home, we might be able to take some of, say, the Adult Core Set measures that are amenable to calculation through T-MSIS and TAF data and just stratify the Adult Core Set measures, let's say, or Child Core Set measures and say, "Here's what it looks like for health home enrollees; here's what it looks for everyone else; here's what it looks like for everyone." So I want to pin that for a conversation later because that might be another way to be thinking about how we get more measures without increasing the burden on states.

Anything else, Linette?

Sorry, no, thank you. But, yeah, that issue of, how do I identify people in particular populations has, I think, been a challenge in many scenarios, not just necessarily the health homes. There's lots we could do if we could identify the populations; and so, yes, you raise a very interesting question there.

We'll pin that for this afternoon after our break.

Dee Brown?

Thank you.

Dr. Basel, I was applauding you, not giving you a stink face when you were talking about doing the race and ethnicity measure because I think that that is absolutely the place that we want to go and correlates well with the coordination of care management piece that I was just talking about with the CoCM model because what can we impact and how can we focus our care managers on those that need it most is really an important discussion that we're going to have later, which I appreciate.

I do want to just raise another concern, which is just this actual capacity to be able to share care gaps known. And you all know I'm working for a managed care organization. In all the markets that we are working with, the health homes, the SUD measures, it's a federal issue to say, "This member has an SUD diagnosis." So it's very difficult for managed care organizations to share SUD information. So to say the initiation

engagement of alcohol, opioid use, pharmacology, those kinds of – and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse -- in many, many states, there are other sensitive conditions. But in all states, SUD is a sensitive condition that cannot be shared without the managed care organization having a member's consent on file to share it with a care management organization. So I just do have a concern about how do we get that consent capability to share that information. Because then we're measuring it, but we're not giving the actionable information saying that this member has an open care gap; can you go address it with the member?

It's only if the care managers are actually asking the member, "Did you get screened for alcohol, and did you get screened...," sometimes mental health is even a sensitive condition. So I am concerned. While we all know that these are good measures of actions, the actionability at the health home itself and sharing that data with them is a big barrier just in general. I wanted to just open that up and see if other people had thoughts about ways that maybe the states have access to that data and could share it with the health homes rather than relying on the managed care organizations doing that because it is not currently happening in the markets that I'm in. The states look to the managed care organizations to share that data with the health homes.

Are there any comments or reactions to that?

This is Linette from California. I suppose – I mean, the issue around data sharing is at the roots to the federal level related to the substance use disorder services. So what we have done with these measures in the past is we calculate it at the state. So as opposed to us sending the data to the health home, we would use the data that we have received to do the calculation and then make sure that it's deidentified before we move it further. So that's how we've addressed that in terms of doing the measures.

That is true. I mean, we do the same thing. I know for each of my organizations what their percentage is, and I can deidentify it. But it's not handing, typically what we do is we hand the measure. Here's your individual member who has this open care gap, and they need to get it closed. And we're telling the health home, "Take action on these," right? And many of the requirements in the SPAs ask that we share health homes, and many of the contracts require – I mean that we share care gaps, and many of those contracts require that we share care gaps with the health homes, which makes absolute sense because a care manager is capable of closing care gaps just by getting the member to their PCP, getting the appropriate referral, and reducing the barriers that members have to understanding what they need to do and actions to take associated with care gaps.

I think that that's, yes, we can report the measure; but we are not able to improve the outcomes for those measures because we're not being able to share that information with the health homes. That's all. So that they don't know, oh, these ten people, I need to call them this month. This is what happened, and I need to take action with them. Unless the member is self-disclosing to the care manager, we're not sharing the data with them. That was my only – it's a comment. I don't know that there's anything any of us can do about it. I just wanted to – we do have a lot of SUD measures on here. When

we were talking about is whether there is something we might substitute, we might want to reduce the number in thinking through that because it's so difficult for us tell a health home, "Here's your members enrolled in your program, and please go do something for them."

Thanks, very helpful.

Carrie?

Hi, yes, just in terms of what might be considered in the future to add, I was just thinking. I think it was Fran that was saying about the prevalence of people with HIV in these programs, and I was wondering if something more specific about HIV would make sense to add. I think there is one in the adult set about viral load suppression. That's just what struck me as something that might be missing here.

That's really helpful, thank you.

Libby? Sorry, go ahead, Dee.

I'm sorry. I didn't have my hand raised.

I think, Libby, you're next.

Sorry, I was double-muted; and there's a chance that Dee and I might have the same reaction. I know that in New York while we use viral load suppression to some extent, there's – for us at least – a similar data sharing concern, especially when it comes to viral load suppression, just given that that's not something that -- we can't share that on a member's level with the health home because it's protected information. And also their ability to impact viral load suppression when you're also relying on disclosure from the member and also that's sort of maybe more down the line than a measure that was focused more on, say like Hep and PrEP or something like that – which I don't really think exists. If it does, that would be great.

It's just it's tough to ask a health home to be responsible for viral load suppressions when we're not able to give any information on a member level. Also, that's sort of multiple steps down the line from that disclosure. So I think it would be great if we *could* include an HIV measure, but I have my own concerns about sort of using viral load suppression just because of the data sharing and actionability, especially when it comes to a health home level. But I also agree if there were one that worked, or one that worked well for the health home setting, I think it would be a really good thing to include. And I think I'd just echo everyone else's note that it's nice to look for gaps; but I think that has to kind of go hand-in-hand with parsimony on the measure list of if we're adding a measure, is there a place where a measure could be removed where there's repetition or something like that. That's all.

A theme that I'm hearing across these conversations is one related to data sharing. I know there are efforts more generally within Medicaid technical assistance quality measurement/quality improvement thinking about opportunities for data sharing, whether it's related to substance use disorder or even HIV viral load suppression. So I

think maybe when we come back to technical assistance later, we might consider whether that's an area that health homes could benefit from other kinds of technical assistance related to how to implement data sharing best practices/lessons learned. And that's something that maybe is a good conversation for the later part of the meeting after the break.

Jim, you have your hand raised.

Yeah, regarding all the HIV discussion, I mean that's important. It may be different in different states; but in Wyoming, pretty much all of our HIV clients are followed in the Ryan White Program and where we actually do – we only have three providers providing care for them statewide, so we actually do track viral suppression, immunizations, PrEP, and all those things in the Ryan White Program. It may be different in other states, but an HIV measure in the health home would not be very applicable in Wyoming.

Another thing that we're trying to deal with is, are we really screening and getting appropriate referrals for the social determinants of health since we don't have any managed care organizations in the fee-for-service setting. That becomes a challenge to make sure that you're not letting people fall through the cracks regarding SDOH, especially the biggest two are housing insecurity and food insecurity.

In terms of data sharing, we just had a long conversation yesterday. We are trying to develop plans of safe care for our Medicaid moms, and we're getting incredible pushback from Title 5 going, well, if you collect things like substance use diagnosis – for some reason, they were terrified of the idea of sharing that data. They want to just sit on it instead of trying to get moms into help. So data sharing is a bit issue and causes some internal agitation, at least in our state. Those are a few of my thoughts on those things.

The only other thing is because of the common comorbidity of mental and physical health, one of our earlier comments was about is there some way we can look about assembling the care coordination between the physical and mental health sides. I think that's an important area that probably because it is challenging, I don't see it really adequately represented. I think just a 30-day follow up is not real adequate. So those are my thoughts.

Thanks, Jim.

Fran, do you have another comment? Your hand is raised.

Yeah, what about screening for Hepatitis C?

What about it?

Let's do it! You know, Hepatitis C is related to lots of different conditions. The guideline is for basically everybody should be screened for Hepatitis C – or, well, adults. There's particular lack of screening for the immigrant population. Basically anybody who's from any continent other than the United States should be screened. So I think it would be

really interesting; it's important; and we can do something about Hepatitis C now, where before it was cost prohibitive. Now we can cure the disease with eight weeks of treatment. So that's one of the things I would suggest.

Okay, that's great.

Dee Brown, I see your hand is raised.

Yes, Libby was correct that she and I would have the same reaction about HIV in New York State and data sharing. As far as a lot of great comments about adding more preventive measures, I'm thinking even with the HIV discussion and SUD, the integrated care discussion and everything else – you know on the Adult Core Set, there are the annual wellness prevention measures for adults and on the Child Core Set same thing. I'm wondering if because we all know that a member who sees their doctor actually can get their care gaps closed because they're getting fully assessed.

And as the states move to integrated care for medical and behavioral health, just having them visit and getting them screened, we know that that can be occurring. So I'm wondering if we want to talk more about the annual wellness preventive measures, and then also curious about maternal/child health measures. I'm not familiar enough with whether there are any quality of care measures for maternal/child health, but that is a huge prevention that we can drastically improve many of our health home members and then third generational children coming after them if we're getting them better pre- and post-natal care. That's a huge health disparity in every state. So I'm curious about people's thoughts on that.

Dee, one point of clarification – on the Adult Core Set, we don't have an annual wellness visit. We do have the Cervical Cancer Screening, Breast Cancer Screening, and now Colorectal Cancer Screening, and measures like that. But we don't have the adult access to preventive care/primary care measure.

I thought that it was on there. Maybe I've forgotten, but I thought it was on as they look back an annual period to see if they got an annual primary care visit.

No, we do not have that. There was conversation about it, but it has not been recommended.

Okay, well, maybe we'll recommend it here, how's that, for this Core Set. It won't be on the Adult, and we do have a lot of preventive measures on the Child. So they are seeing the physicians. I'm just wondering if by having that, we can get around the data sharing issue because if they're seeing their physician and the physician is knowledgeable about their HIV or they're knowledgeable about their SUD, and we're measuring integrated care, then we know that we hopefully can focus the health homes on making sure.

Because we still see many members who are in a health home who are not getting their annual primary care physician, and we also measure to see if they've had it quarterly. On a quarterly basis – so more frequent – so we look at annual and quarterly. And a lot

of these members who were in need of a lot of services are not well-connected to a primary care physician. And where we focus on measures, that focuses people's attention.

Great, thank you. I don't see any other hands.

Oh, sorry, this is Fran again.

Go ahead.

I'm sorry, am I monopolizing the conversation?

Not at all, go for it.

Okay, just there's not great data that an annual physical from a primary care doc changes outcomes – that being said – that we can measure. That being said, it doesn't mean it shouldn't happen in terms of establishing relationships and getting them connected to care on any of the chronic conditions. And then there's, of course, the coding issue of what is a primary care visit and for what. I think that all that can be worked out, and there certainly is something that the health home can do – the folks in the health home can do to get folks into clinic or sort of, assuming there are primary care physicians and there are appointments available. So I think I totally agree with you that preventive care needs to be provided – and I don't mean to be a naysayer – but, well, it's a challenge, like most of these measures are.

Thanks, Fran.

All right, any other comments before we move into the final part? Libby Nichols.

Sorry, this is just a quick follow up.

Fran, you had mentioned a hepatitis screening measure. I may have missed one, but I don't think that there's a HEDIS measure specific to that. Are you currently using a -- like a measure that you know of or something? I am looking into that for—

No, we're not.

Okay, I was just curious.

It's just a gap that I would love to see filled. That's all.

Yes, agreed, I was just hoping you had something further on something.

And I think some of the delay is because there wasn't much we could do about it, right? So now that we can do it and, frankly, the price has gone way down – and particularly since the guidelines have changed regarding treatment. Now if it's sort of a simple case of Hepatitis C, if the individual doesn't have cirrhosis, you don't have to get consults anymore. Nothing is ever easy, but it's certainly not as complicated as it used to be. So I think that's probably why it hasn't. We're working on it here in Maine -- not necessarily the measure itself but getting a statewide program.

Gotcha, thanks.

Any other comments?

All right, well, now I'm going to put everyone on the spot before we take a break. I'm going to do a round robin and call on people to identify one gap. So this has been a great, great, great conversation all morning actually into this afternoon. But I'm really interested in hearing from you what resonated with you or what other thoughts you have about a gap for Health Home Core Set. That might help us to ultimately prioritize and distill this information if we go around the virtual room and have people just say what resonates with you as a gap. If you heard somebody say something and you want to plus one, that's okay too. So I'm going to start at the bottom of the list and start by calling Laura Vegas. Can I call on you to say what is a gap that you see in the Health Home Core Set?

You sure can. I'd like to see – well, this is probably not specific enough but more around the – to look at the effectiveness of the reason for health home and my understanding is it is the care coordination service.

Laura, you're breaking up a little bit; but I think you said something about effective care coordination. Is that what I heard?

Exactly.

Whoops, I might have gone on mute, sorry about that. I'd love to hear if you have anything more to say about effective care coordination as it pertains to the Health Home Core Set.

I'm thinking in terms of, do people know who to reach out to in terms of their care coordination? Is there an entity? Kind of like, you know, the measure we were talking about earlier that we didn't want to include at this time, but do people understand what care coordination is? Do they know that that's available as a service? Just do people understand that that's something there for them to help coordinate all their care?

That's great, thank you. Sorry to make you go first, but thank you.

All right, Sara Toomey, you're next.

Thanks for unmuting me. I guess what resonated with me, one, was looking at different aspects of disparities and thinking about how those apply here, especially when we think about different types of disabilities in addition to geography in addition to some of the more classic socioeconomic and sociodemographic factors that we think about.

The other thing that resonated with me is thinking about whether or not we could incorporate or take advantage of the fact that the Medicaid Adult and Child Core Sets are currently being collected and will be mandatory and whether or not there will be an opportunity for us to stratify those measures to look at participants that are in the health home programs versus ones with similar conditions who aren't versus the more general populations that are included in Medicaid.

Thanks, Sara that's great.

Linette?

So I agree with the care coordination piece, so I plus one that. But I'd also still put a plug in for the preventive services. I know it's hard in terms of who has responsibility related to that, but I think it's important we don't lose track. Thanks.

Thanks, Linette.

Libby Nichols?

I think I'd choose social determinants of health as a gap that I think the health homes probably spend a substantial amount of their time working on. So it would be a great way to really see the results of what they spend their time doing. I think that would be my focus of choice.

So are you thinking about -- when you say social determinants of health kind of bringing it back to what Jim was saying about doing the screening, referral, and follow up? Is that what you're thinking?

Yeah, I mean, I think the reality is that's sort of the tone of the measure that's most likely available right now or going to be available. But I think – at least I know in New York the health homes spend a lot of time screening for things like housing or food insecurity and then following up and resolving that or connecting to resources. So I think that that's sort of something that because that's what they spend a lot of their efforts on, I think it would be a good way to sort of measure.

Great, and do you use a standardized screening tool across all providers; or is there latitude on that?

So I mean this was all a little bit in process. Across the health homes, we use the AHC HRSN. I can never quite get the acronym right.

Right, Health-Related Social Needs?

Yup. So all health homes use that screening questionnaire specifically. And there's efforts to kind of figure out as for other providers and for plans what sort of screening tools could also be used in addition to that or kind of how to coordinate and standardize across the state and across providers. But among the health homes, it's standardized.

Great, thank you.

Pam Lester, you're next.

Yeah, I agree with the utilization or adding of coordinated care measures. Are we coordinating those care needs? Then also agree with social determinants of health. I think that's something that we haven't put enough focus on. One of the struggles with that we've seen is alignment in the questions that are asked. Our chronic conditions – some of them use what's called a PREPARE tool. It's with our federally qualified care

centers. But they just struggle with having uniform questions to be able to kind of look across the board. So I think having to add to that, to earlier points, to have a tool that is considered a best practice would be really helpful in kind of pushing maybe that forward, in addition to measures that would complement that – sorry about the rambling.

No, that's great, thank you.

Amy, you're next.

Hi, everyone, this is Amy Houtrow. For those of you who know me well, I often worry about things being much more complicated and getting more complicated for the user, the individual person with the health conditions. So for me, the pie in the sky kind of dreaming sort of thing would be – would there be measures that would indicate ease of use, moving through the system, getting what they need in a timely fashion. I do think that relates to the issues around care coordination but really get at a part of care coordination which isn't about adding more levels of things but making sure the system serves the people that need it well. Obviously, it's very hard to pull out how to get this information; but if I were dreaming, that's where I think we would move in terms of measures.

That's great, thank you.

Karolina?

Hi, this is Karolina Craft. I completely agree with the care coordination piece and just understanding if health homes are actually successful in coordinating care.

I think that the social determinants aspect of this is really important. I cannot think of a measure that we could standardize. But if we had a standardized measure, I think everyone would agree that that would be a great benefit. And, I know that there is like an option to report rates by race and ethnicity. I kind of feel that we might want to move into making that mandatory and just knowing the race and ethnicity stratification for all of the measures here.

Great, thank you.

Jim Bush?

I always have to find mute button. I think all these are good points. But given the fact that we know that when people have comorbidity of a mental health and a physical chronic condition, they can be more expensive. Their diabetes is more expensive, their COPD, their heart disease is more expensive. So I think if I had to pick the highest priorities, it's again that coordination between the mental and physical health because that will help to drive down the costs of both. So that's sort of why I'm going with that one. It's going to be a deuce of a devil of a measure to try to come up with; but as someone said, if I had my dream/ideal, we'd have a measure that would help to address that.

Thank you.

Dee Brown?

Well, this has been a really good discussion. I have to pick one, huh? I think the care management measure from AHRQ that is out there is good, but maybe we would need to work with AHRQ to add in administrative claim codes for health home in the tech specs to say it would really be measuring what the health homes are billing for so that we know that a member is in a health home.

They could also look for collaboration of care codes in the states that have that in their Medicaid rate schedule. So right now, they're looking at care coordination billed by a primary care practice. So I think there would need to be some work there. But I think if I had to pick one, it would be that because it would get the preventive primary care services component. It would also look at health home services, and it would look at collaboration of care for medical/behavioral health. So if we could work with AHRQ to modify that measure for the tech specs for health home, that would be probably what I would do.

And I just wanted to make a note on the SDOH. I agree with everybody that's the biggest time spent by health homes. And CMS from the CMS Innovation Center just did adopt a potential measure development for SDOH this last year. So hopefully, that is forthcoming.

Thank you.

David, you're next.

I really appreciate you starting at the back side of the alphabet this time to give me some time to formulate my thoughts on this question a little bit. I keep feeling like I'm trying to jump the agenda to this afternoon's agenda with some of the disparities and the social determinants discussion. That's where still my mind is.

Whether you look at it as a process measure of did you screen for social determinants and do appropriate referrals versus do you just stratify all of the other measures for the social determinants and look at the outcomes from that standpoint, and if the process is good then your outcomes are going to be – the gaps kind of close. I think I'm talking myself more and more into just stratifying it and let the outcomes speak instead of adding a new measure, a process measure, for that because we thought we needed that as an immediate tool to see why our disparities aren't closing. We could make an argument there.

The other aspect as far as trying to standardize the social determinants, I've got already Medicare's inpatient payment rule that came out did kind of set the stage with their preliminary rule that came out on which social determinants they're going to mandate that hospitals screen for at admission. That will kind of set the stage a little bit for other areas. I've got to read through the inpatient or the ambulatory professional fee schedule preliminary rule to see whether they included similar language in there yet. I haven't seen it reported, whether it's buried in there somewhere in there as well. But usually, it follows about a year behind the inpatient side to kind of add things like that in. But I

think CMS is going to standardize some of this, at least what categories of social determinants they're interested in if not the actual questions that we ask within that category.

Great, thank you. I like the way you framed it...do we do one or the other or both? That will be good for later conversation.

Carrie?

Hi, I was thinking – I mean, I agree with a lot of these as being important – the social determinants of health and prevention and care coordination. It just was occurring to me that maybe a potential solution would be the use of a consumer experience or by a standardized survey by CAHPS that would address a lot of those issues, and it would potentially answer questions about demographics and health disparities if it was like the Health Plan Survey for adults or maybe even for families. I was just trying to think of something that could address a lot of these, and that might be something as well as getting at the ease of use I think that somebody suggested. That might add a lot to our understanding of how well these programs are working.

Thank you.

Kim Elliott?

Hi, I also agree with a lot that's been said; and I think that if we're doing really good care management and have good care management plans, it'll drive a lot. But when I think about health homes and the population that we're really trying to work with, health promotion is probably the most important thing for me to think about from a measurement perspective. If we're not – we spend a lot of time looking at the chronic conditions and ensuring all of the recommended care and services for chronic care are taken care of and we're following guideline recommendations to best manage those conditions. I think sometimes we then overlook some of the annual well visits, the screenings, and the things that are going to improve overall health for the population. So I think the gaps for me would be in the health promotion area and ensuring that the PCP visits are occurring -- weight management, those sorts of things. Because all of those are really impacted by chronic disease and chronic disease management and some of the meds we take and just the care and service delivery in and of itself.

Thanks, Kim.

Fran, last but not least, you have the last word before the break.

Oh gosh, well I'm, like I said, a big fan of Hep C screening, which speaks to I think what a lot of people are saying in terms of what's the role of the health home – is to support the individual where they are. And they have a lot more time to get into their world. I'm also very interested in improving the care of the I/DD population. I'm not real sure if I get to that, but we can sort of talk about that. It speaks to health disparities. We'll talk about that this afternoon, which I'm looking forward to. I also agree with some sort of – as much as I have concerns with the challenges of the CAHPS survey, there aren't any

patient satisfaction measures; and ultimately, they're the ones that we're serving. So it would be nice to be able to get their opinion somehow.

Thank you, everyone.

David, do you have a comment before we break?

I just wanted to tag onto the last comment a little bit on the annual visits – a kind of preventive kind of discussion – because I almost said for my one item right along that same line. I talked myself out of it and the fact that these individuals being in health homes almost automatically are tied into primary care a little bit better than if they weren't in a health home. That's kind of the whole idea behind the health home, I think. So I was trying to decide whether that's a true statement or whether we still are fragmenting care in health home. Even though we're calling it health home, we do need to measure that. So I was just going to ask what others thought of that because I kind of talked myself out it – that we select it for a population that did have a health home already.

Well, I see that, Dee you have your hand raised. But I'm going to take the prerogative of calling for the break. When we get back, we will certainly pick this conversation up again. After the break, we'll be talking about future considerations for the Health Home Core Set; and we can take it any which way we want.

With that, we are going to reconvene at 2:00 p.m. We look forward to having you back, so please be back by 2:00 p.m. We're going to go on mute until then. Have a good break, everyone; and thank you for a great conversation.

[Break]

Hey, everyone. It's two o'clock. Welcome back from the break. I hope everyone had a nice break. Now we'd like to spend some time discussing future considerations for the Health Home Core Set.

Next slide, please.

So this slide lists the topics for discussion, where we're interested in Workgroup feedback. We'll start with a discussion of the use of alternate data sources for Health Home Core Set reporting. We talked about that a little bit earlier. So we're interested in hearing more feedback on that. Then we'll discuss measure stratification; and finally, we'll open the floor to any other considerations Workgroup members would like to discuss.

Next slide, please.

So as we talked about earlier, to reduce reporting burden and also promote consistency across states, CMS is exploring the use of alternate data sources for Health Home Core Set reporting, such as the use Transformed Medicaid Statistical System or T-MSIS data. And we're looking for feedback on what the Workgroup has to say about the

potential for CMS to use alternate data sources to calculate health home quality measures on behalf of states.

So with that, why don't we just open it up. Well, actually, before we do that I do want to talk about a couple of the challenges; and then we'll just kind of dive into it altogether. We have identified a couple challenges related to T-MSIS data quality as we talked about earlier. We've observed first of all that health home enrollees are not consistently identified in T-MSIS data even though there is a health home enrollee identification flag.

Another challenge is that health home enrollees are not attributed to a specific health home program in states that have multiple health home programs. So for Health Home Core Set reporting, that would be a problem because we wouldn't be able to get health home-level, program-level data.

So on this slide, we've listed some discussion questions for your consideration and wanted to hear from you about your general feedback about the use of alternate data sources and then also any thoughts you have about addressing some of these challenges.

So with that, open it up to anyone...Dee Brown?

Well, being an individual, thank you, who oversees multiple state health home programs and the managed care organizations are the ones expected to collect the data, the T-MSIS data is not something that we have had as an indicator or one that any of the quality programs that we use are capable of measuring that. So I am curious about other's thoughts with that. And if the health home enrollees are not consistently identified and it's not attributed to a specific health home program, it's not helpful to the health homes because we give them the data and we also give it to the state; and then the state reports it to CMS.

The state is also doing aggregation of data that they get from all of the managed care organizations. So in states that don't have managed care, I can understand that this might be something they would be wanting to do; but so many states use managed care. And the states that do rely on the managed care organizations -- and they would have to have that from multiple managed care organizations in the state because there's not just one -- it would be a challenge, I think, from that juncture.

Yeah, I'm glad you brought that up. It's more of like a top-down process as opposed to a more bottom-up process. So as you pointed out, managed care organizations report up to health home/state/CMS. Whereas in kind of the T-MSIS model, it would be more of a top-down sort of retrospective type of calculation of measures. So I think it's a different model and appreciate your raising the distinction.

Yeah, and one of the chief complaints we get from both health homes – you know, we do surveys of the health homes in our primary care practices. One of the chief things that we get feedback through those ratings is actionable data – what the providers who are doing these services, and I do want to make a statement right before we went on break that Dr. Basel brought up about his assumption that everybody gets connected to

primary care. It doesn't happen even in health homes, unfortunately. So my concern about being able to have the health homes have actionable data or have primary care physicians have actionable data, this to me doesn't seem actionable. It is what you said; it's a research model dataset, but it's not actionable data where somebody can take that information and do something with it and actually effectuate a change in somebody's else status.

Yeah, so a quality measurement model as opposed to kind of a quality, real-time sort of quality improvement quality measurement interaction.

Right, and so we have in our care management systems – to the second bullet here – we attribute the assigned members and those that have enrolled and opted into the program differentially in our care management systems so that we can coordinate care with our internal care management teams and not duplicate services. So, yes, we're at a health home level; and we're producing care gaps using the Core Set for our health homes and distributing that for members who have an open care gap in the program.

So that is something that we are doing and at a health home level; and that's important, I think. The data quality or completeness with the health home enrollee codes is in some states – not all – most of them they give the members from a file, or there's an algorithm that we run to identify somebody eligible for health homes. So either one or the other, but there are some states where they just tell us, "This member has been identified for health home," but you don't know whether the person is enrolled or not because we don't have the line of sight. So when you look at people who are identified for health home versus those that are enrolled, there's very different results in quality measures. Just saying somebody's identified but if they're not being served in a health home, I think that's a very big difference in what the data is saying to you. Because the ones that are not could be being care managed at a different type of program if they're not enrolled in a health home, they could be getting other care management services from another program, like a managed care program. So I think that data quality piece is a very big issue in some markets.

Do you see variation across the states that you work with?

Oh, absolutely, we have a saying, "If you've seen one health home, you've seen one health home." So some are non-clinical; some are very clinical. Some are downstream care managers and upstream networks. It varies in every state. If you look at the SPAs, they're all *very* different. Who participates is different, how they qualify is different, and then how they pay is substantially different.

Right and to clarify – I apologize – I meant in terms of data quality. Do you see variation in data quality across states? And could you identify any kind of root cases of variation in data quality that could maybe help us look for ways to improve data quality or completeness? And you might not be able to answer that now.

No, to answer that question, one state that we oversee is a state that we cannot see whether they're identified as qualifying for health home or that they've enrolled. And in that dataset, we see a very different outcome in quality because we're not really

measuring people in a health home program. We're just saying, "Here's people who could benefit from a health home," and some may be enrolled and some aren't. So the data quality -- if you can't differentiate between who has opted into health home and who is just eligible and identified for health home, it's a very big qualitative difference.

Great, thank you, that's helpful.

Jim Bush?

Yeah, and I appreciate the recent comments there. We have a 100% fee-for-service state, so no managed care organizations in Wyoming. I would just say that we were some of the experimental groups with the T-MSIS, and we have found T-MSIS to be a wonderful system for us. We do – we're the ones who do all the attributions; so we're very much – we sort of drive things.

We've been pretty much a claims-oriented state; but one of the things we're starting to explore is how do we use the data in our HIE because we got a lot of our hospitals and clinics now connected to our HIE. So how can we start using clinical data more real time is something that we're really starting to explore. We're doing it with several maternal projects right now; but as we're learning, I could certainly see it expanding out to other areas.

So I think with the evolution of the technology, we're going to find better ways than just claims data. We've always been against the chart review type of measure; but I think when we get to the point where we can scan it in HL7 format and be able to electronically extract data, I think those will become more useful rather than just going for claims. Like we will be able to see how many people have the A1c and what is the A1c and can we start rewarding better outcomes of A1c, better outcomes on blood pressure control, et cetera. So we're just dabbling with those things, but I think it's going to be really a gamechanger as we get more experience with this and more people connecting.

Thanks, Jim, that's really helpful looking to the future as digital measures as well.

In regard to the HL7, it's a great way to capture care gaps and to report that out because it's a standardized HEDIS set. I agree with Jim. One thing is HL7 doesn't give you a place to say give care coordination a call for this member. So if we're talking about alternate data sources, could we look to add to the HL7 to include care management information? That's a question. It would be a dream in a perfect world.

And that was Dee?

Yes, that was Dee thank you.

Okay, thank you.

All right, that's great, thank you.

Libby Nichols?

Hi, this is Libby. You know, I don't have – like I'm not the point person in New York for T-MSIS, so I don't necessarily know all the ins and outs. But I do have an idea that acknowledging that the reporting is retrospective anyway, so this is all kind of at the whims of data lags regardless.

One potential way that could be used for identifying – and I'm assuming that this is something that comes up in many other states, but I don't really know for sure. We have a series of codes in the Medicaid system. They really started related to those few maybe who were excluded or excepted from managed care but over time have become flags for other things, and one aspect of it is often there are flags to ensure there's not duplication of services.

So for us, one way that's pretty easy -- or at least would be relatively easy to identify health home enrollees that would also be program and time specific -- would be using those codes. And for us, they're called "restriction exception codes" or RE codes. But I am guessing that other states would probably have some similar approach to flagging members in certain programs related to kind of monitoring or avoiding duplication of services. So I don't know for sure, but I would assume that that might be something that would be a common practice across states. While they may not be all formatted – like they're not going to be all formatted correctly, but I think there might be some way to do some standardization sort of at the back side of that that could help because I think from a reporting burden stance, I think most states would appreciate the ability to not put time into the reporting to CMS if there was another option out there, especially if it's going to be used for the Adult and the Child Core Sets.

So I think that would be something that's worth troubleshooting if possible. And I'm wondering if sort of both duplication of service codes if that might be a way to kind of flag which members are in which health home program at one place in time and might be something that's somewhat similar across states.

Your mentioning those codes reminded me of something that I heard somewhere about coding is that I think might have those codes, but it might not live in their MMIS. It might be in a separate file. So then how does it all get linked together, and then how does it get brought into T-MSIS in the conversion or transformation to a T-MSIS file? So I think if any state has insights about where that information lives and whether it lives separate from, say, an MMIS, that might be helpful to hear as well. So thank you for that.

Other comments about using alternate data sources – the MMIS T-MSIS being one example. We heard HIE as another example. Other comments?

Linette?

This is Linette. So I work on Core Set measures, and I work on T-MSIS as well – so a variety of other data things in California. So just kind of to tie together some of the comments that have been made, T-MSIS is inherently retrospective. So we in California – we load our data from our transactional systems into our data warehouse, and then we use our data warehouse to transmit T-MSIS. So T-MSIS and our data warehouse

are the same, and then we use our data warehouse to calculate our Core Set measures that we send to CMS. So from that perspective, there's consistency.

The issues that come up in terms of what we typically have concerns around is if CMS were to use the T-MSIS as opposed to what we're doing locally. One would be claim-like issues because we update data to T-MSIS monthly. So if we typically run our Core Sets measures, say, in September, to have the equivalent data in the T-MSIS TAF file you'd probably have to wait till January or so. So there's a timing aspect in terms of from when we transmit and then it gets loaded and then it gets turned into a TAF and all of those kinds of things in terms of whether it's run from T-MSIS versus run locally.

All that being said, the T-MSIS data is not available for local care coordination or monitoring at the plan/provider/health home level. It is retrospective. So it's good for doing things like Core Set measures, but it's not good for doing real-time monitoring. The other aspect though that we do do because we're a large managed care state is that to the extent that our managed care plans are running particular measures and they report them to us, as they're required to in their contracts, then we will use what they reported for a particular measure.

We can use the denominator specifications to exclude those people from our population in the warehouse, and then we run – we use our claims data to fill in for the people that are not on managed care plans because we still have somewhere between 5% and 15%, depending on population, that are not in a managed care plan or maybe are not in a managed care plan for 11 or 12 months to meet the denominator requirement. So we pick up those with our administrative data, and then we combine it all together to create our state data that we submit to CMS for core measures. We have basically done similar things for the health home measures as well as using that data repository to run the measures, and essentially we'd already done most of the measures for the Core Sets. Then we were able to tease out and stratify on the population in the health homes.

But in terms of identifying the people in the health homes, one of the challenges – and this going to be a challenge for various kinds of programs – the way the T-MSIS data is set up from an eligibility perspective is to identify the statutory/regulatory eligibility group. So there's the T-MSIS eligibility groups, and they tie to particular statute and regulation in terms of eligibility. And people are -- beneficiaries are to land in one category so we don't have overlap between the categories when we do the eligibility information. So when you have somebody who's in an additional program that's beyond their base eligibility, then you're asking it be collected in separate way – which is what's been done on T-MSIS. There's separate fields to identify somebody who is in health home; but as you said, it's not specific enough to identify which health home.

So that's inherently going to be a problem and probably going to be a reason that would be hard to use T-MSIS to do the Health Home Core Set measures unless the state were to provide essentially a finder file. But we don't think of T-MSIS as being outside of the MMIS or the MES. The shift has been from MMIS, Medicaid Management Information System, to talking about MES, the Medicaid Enterprise System. So our T-MSIS reporting comes from our MES or our MMIS. It's not a separate activity. It's part of that.

But each state is going to be a little bit different, depending on how their systems are set up and how that's all flows together. So hopefully that helps kind of tie some of the comments together with some context.

This has been really helpful. I think what I'm hearing – because we spend a lot of time thinking about this for child and adult, but I'm hearing from health homes that there's almost a different perspective about that real-time performance monitoring/quality measurement actionability and not so much that top-down sort of retrospective quality measurement. So it really is very different, and I think this has been helpful.

I see Dee has a hand raised, and I guess Karolina. So just queuing up anyone else who wants to speak to this and any of the challenges or the opportunities would be great.

Dee?

Well, looking at alternate data sources, I'm curious about other people's view of some of the states have either done legislative mandates or modified even after having a health home program, same thing with North Carolina, where they have advanced medical homes, or Minnesota, that have health care homes and integrated health partnerships -- states that have a lot of people enrolled under the Medicaid programs in provider organizations providing care management.

So thinking about alternative data sources doesn't necessarily need to map to a state who has a SPA approved for health homes, could it be expanded to include additional data for some of these other states who have providers providing care management? California just changed from health home to enhanced care management. So in those places where they have modified but still are having programs in the community where people live and want services, that capability of being able to expand alternate data sources beyond health home to any provider providing care management might be something that we would want to consider. It would expand the number of programs. It would also let us see which care management models in the community work better.

So that's a great big-picture perspective. I think for the purpose of the statute, however, there are very specific requirements for Health Home Core Set reporting that does relate back to the SPA. So that, for example, if California has changed its program, no longer has a health home SPA, they wouldn't be subject necessarily to Health Home Core Set reporting. So I think what we want to be focusing on here really is the requirement for Health Home Core Set reporting, but I appreciate your bigger-picture perspective from an analytical and care delivery type of perspective. I think what we're looking at, what we're charged with, is thinking about the SPAs, the programs that are specifically called Medicaid health home.

I just want to do a time check and see if we have any other comments related to use of alternate data sources for Health Home Core Set reporting and any other insights about the data quality, how health home enrollees are identified/attributed to health home programs, any other data quality or completeness issues you're aware of, and any other opportunities that might exist to improve data quality and completeness.

I think we're going to be talking – this is Fran. I think we're going to be talking about this a little later and maybe this is opening up a can of worms, but it seems to me that there should be a way to figure out attribution. I mean, all you have to do is like put an asterisk in the claim system somehow. I understand it's much more challenging probably in managed care; but in fee-for-service -- maybe that's an area for TA moving forward.

I have a follow up question a little bit, and I think this is primarily for Linette. This might be more in the weeds than maybe we want to go today. But if a T-MSIS had less or had an ability to not necessarily have mutually-exclusive beneficiary information – like the ability to put multiple flags on a specific beneficiary, an attribution – would that improve -- sort of like would that be a thing that's one step closer to this being feasible? Am I interpreting—

Yeah, there's various kinds of categories. So there's lots of data elements in the eligibility files. I mean one of the data elements in the eligibility file is around how people are eligible. So that's the T-MSIS eligibility groups. There are various data elements that get at whether – like what folks' citizenship status is, whether it's CHIP or SCHIP or what have you. So there are a bunch of different fields, but one of the challenges I think we run up against is when we start thinking about program eligibility specifically. It's kind of like what plan are they enrolled, or what program are they in. One of the challenges with the health homes and one of the things I think we've seen some challenges with, with some of the kind of newer, more-focused programs is that our systems don't have kind of that enrollment piece. So like when people are enrolled in a managed care plan, there's standard HIPAA transactions that are sent to identify who's enrolled; but that's not necessarily true of some of the programs. So this is one of the things we ran into with health homes and with some other kinds of programs is essentially we're receiving an Excel spreadsheet from the plan that says, "These are the people enrolled in this program."

So it's not fitting into kind of the overall large mechanism of the various kinds of transactions that move through, and there ends up being a certain level of manual intervention. When we do things like RTMs -- obviously California is really big, our eligibility file each month has 250 million records -- we can't do manual stuff in that context, right? It has to be part of our automated systems that runs through. So it's not that it's impossible. It's not that it can't be done. But it's important to kind of think about how these kinds of data are captured to flow through and to what extent do they fit on kind of standard transaction files that are part of HIPAA-compliant transactions as well as other kinds of categories. That maybe helped or didn't help, but...

No, that did help. I guess, I mean I think New York has some similar aspects from that. Its beneficiaries are – we're on a big scale, and also we have primarily mandated managed care. So that was sort of my like thought about going down the duplication of services, is that when someone is enrolled in a health home and they're billing for services, those flags get turned on within our – really it's driven sort of more by our data warehouse.

While I recognize that really – what I'm sort of trying to get at is there a specific ask that we could give to T-MSIS, like here's the three things that would be required to make this feasible. Is there a way that we could find alignment on what that ask would be? Because I think – and I think you probably have a lot more insights on this than I do, but it sounds like there are some definite barriers; and that it would require some accommodation from T-MSIS. But if there's a way to identify what those pieces would be, maybe it would help us – get us one step closer. And maybe that's something for a more detailed discussion later.

Yeah, it would probably be something good for Mathematica/CMS to take back to the T-MSIS team and have it be part of a broader conversation around how do we capture people being enrolled in particular programs. And maybe it piggybacks on the waiver because one of the other things we do have to report is if somebody is more than one particular waivers. So maybe there's a connection there that would be appropriate. So there's probably options; and it would probably be good to have it taken off as a sidebar, so to speak, to think about. I think right now the way that it's set up in T-MSIS – at least last time I looked at a data dictionary – there's data fields that just say – it says health homes or not. It's not as helpful as it might be.

Linette thank you. I think that is really helpful to raise as a question to take back. This is a long-term strategy. This is not a tomorrow thing. It will take time in terms of data quality and just general approach to, like we said, the attributions, the calculations, things like that. So I think this has been really helpful.

Is there anybody else that wanted to – oh, Jim, do you have another comment?

Yeah, I was just going to say that we've actually found – we played around with it a little bit, but pretty much because of the – the trickiest part is the patient is of course always free to change their primary care. So we go with was it a more complex, complete physical coded and by whom. We discount any ER visits or hospitalizations that doesn't count toward attribution. If someone sees someone like three or four times and they only see this other primary care once, we – so that's – because we only will pay for the medical home fee to one provider a month, but that provider can be different on different months. But we haven't really had any real complaints after we finally worked all the bugs out on attribution. But I do think it's a lot easier in a fee-for-service state.

Jim, I think that you get the last word on this topic. Why don't we move on? We can always come back if there's extra time and people think of other things to talk about.

Let's go on to the next slide.

Here we wanted to talk about health equity, as you know, is a priority for CMS and states. Use of stratification in reporting measures is one way to advance health equity to the Health Home Core Set, and this came up several times this morning as an opportunity, along with measuring social determinants of health screening.

So here, as I think you might know, states have had the option to stratify Core Set measures in the past, but very few states have done so. We're interested in Workgroup

feedback on opportunities and challenges related to stratification of measures by race, ethnicity, geography, language, and disability. We've listed some discussion questions on the slide for your consideration.

I know that there was also a question that Dee Brown had raised about whether race and ethnicity are included in the T-MSIS dataset, and they are. In some states they're very complete; in other states, not so much. There is essentially a data quality rating of low concern, medium concern, high concern, and unusable. So if you're interested in knowing where your state is, we'll send you a link after this meeting. It's variable, but it is there; and we're looking at ways to try and make it more complete and more usable and learning more about what state opportunities, best practices, lessons learned are as well as we think about moving toward stratification in the Child and Adult Core Sets.

So here we are now talking about ways to advance health equity through the Health Home Core Set and wanting to know whether your state has stratified any Health Home Core Set measures to assess performance and, if so, what was your experience?

I'm not seeing any hands raised. Is there anybody that wants to speak to this or maybe speak to barriers that exist in stratifying Health Home Core Set measures by race, ethnicity, geography, language, and disability status? For example, data availability; consistency of categories; or other barriers?

Linette?

I think one of the challenges that comes up with some of this is just sample size, so to speak. So depending on how many people are participating in your given health home program, you may or may not have enough volume to do some of the stratification; or it may be relatively limited – so just highlighting that that can be an issue, especially when we get into some of these measures.

I know when we were running some of the measures without any stratification, sometimes we even had to suppress because the counts were so small. So I know one of the things that we're all trying to focus on is doing the various kinds of stratifications that we can; but we do run up against the small cell size issue sometimes, depending on the program and whether it's big or small and what the measure is and what that looks like.

The other thing that comes up around race/ethnicity that we certainly see is "unknown" responses. So that is something kind of just to put a flag on. Depending on the program – like when we looked across state programs, depending on the program some programs have higher percentages of "unknowns" around race/ethnicity than others just because people don't feel comfortable saying or they don't want to give that information. So one of the challenges, I think, is how we educate those that use the data and educate back to the people that we're collecting the data from that it does impact the way we design programs and develop policy, having a better understanding around some of these categories – and particularly around race/ethnicity, I think.

Language spoken in some ways tends to be a little bit more complete perhaps just because to the extent that people are indicating what language they want information in so they can understand it. But that is also kind of a different way of looking at it. Although when we've looked at language spoken and compared it to race/ethnicity, we'd see quite a bit of concurrence between the two. We've kind of done that as point-in-time analysis of some different points in time.

In terms of disability status, thinking about how we define disability status and doing that consistently, that is something that I know we've had various conversations on and we're going to try to dive into more deeply. Is it based specifically, again, like on a T-MSIS eligibility group; or are we using something else in terms of how we identify disability status? Because it could go from being relatively simple to being incredibly complicated, depending on how that's done. And maybe that would be a good subgroup or like technical assistance kind of focus group conversation around disability status more broadly.

Geography is relatively straightforward; again, it's just what size do you do to have it be meaningful. I know when we look at counties, we have some counties that are small and some counties that are super big. So county-to-county comparison is not necessarily helpful; but thinking about what are geography comparisons that are useful would also, I think, be helpful. Sometimes geography is a good way to do it; it's just like rural, urban, frontier, et cetera, as opposed to specific geographies.

So those are just some general thoughts on the different kinds of stratifications and recognizing that in the health home population because they are very specific populations, there may be some challenges in terms of some of the reporting just because of population size.

Thanks, Linette.

Karolina?

So from my experience maybe from a year ago working for a state, I felt that there was finally change toward thinking about race/ethnicity stratification as just a normal part of HEDIS measures or any quality measure production. One of the reasons I think why the state was moving into this race/ethnicity stratification as just part of production of quality measures was because NCQA developed standardized like ways of categorizing race/ethnicity for a couple of measures. We were anticipating that this stratification would be just part of all of the measures going forward; so we started doing it basically for all of the measures, which also created a need to supplement data.

I think if we think about like just race/ethnicity stratification as part of production of quality measures, then we will find ways to supplement data. I think that the need will kind of help just make it happen if that makes sense. That this will just become a normal part of evaluation of quality. That being said, I completely agree with the person who was just speaking about the fact that for the Health Home Core Set, there probably will be instances where the population is very small; and we won't be able to publicly report some of this information. But it certainly will be very helpful to just know -- for a state

Medicaid agency just to know if some information cannot be reported publicly. Maybe this would also create some necessity for managed care organizations to start supplementing data from their sources that they have access to and not only rely on the information that they get from the states.

Thank you, Karolina. That's really helpful.

One of the things I'll point out is that the standard that's being used for race/ethnicity categorization is the 2011 HHS standard. So you'll see that in quality measure reporting systems and the QMR that's going to be opening in September. I believe it also aligns with what NCQA is doing. So that is the standard that I think is tested or kind of the gold standard that quality measurement in Medicaid and CHIP will be moving towards. So we definitely recognize that that's not necessarily aligned with what all states are doing, but it's something we want to learn more about – how to get them all aligned ultimately for the purposes of Core Set reporting and quality measurement.

So thank you for raising those issues.

Anything else, Karolina?

No, I just wanted to say thank you.

Thank you. Okay, thank you.

Laura?

Hi, I can't speak directly to health home stratification; but in NCI/IDD measures, states in the last couple of years have really started paying attention to making sure that the samples that they're assembling for the NCI responses are representative of the ethnicities and minorities in the communities for which the people live. And just for some information for this group – probably not anything you don't already know – it's really changed the sample sizes that they're having to pull. So it's really growing the work that they're having to do and the number of interviews, for example, they're having to do. So it's really changing the way they're having to do the work and the way that they're thinking about doing their work. That's probably no surprise, but that's something that we're having to look at in NCI to make sure that we're really pulling representative samples across the states, to really look to make sure that we're having real representation across all ethnicities and races.

Laura, thank you so much for that information. It's definitely something that I know you know we're thinking about for the Adult Core Set and stratification of the NCI results in the Adult Core Set. So I'm sure we'll be talking about this more and what states are doing, how they're doing it. I think your point about the implications for sample size is really important as well.

Other comments on this topic? Thinking about technical assistance, any thoughts about that? Anything you want CMS to hear about what the needs are?

Feel free to jump in. Karolina, is your still hand up from before; or do you have another comment?

Well, I do agree with the sample size. This is Dee Brown. I do agree with the sample size issue for stratifying the data. I think that's the biggest barrier to doing the stratification when you've got a small sample size. When it's a general population for all members in a health home, then it's easier; but if you've got a small sample size – say you've got 400 people in a measure set that you're using as the sample size, but you've got 10,000 people in health homes, is that really representative of the race/ethnicity stratification for those participants? There is a problem that we had in looking at those that have a sample size measure of how many members were in the original sample size for the general population that were in a health home, so that it just makes the sample size much, much smaller.

Thank you. Anything else before we move on to the next slide on stratification?

I know, David, you brought this up earlier. I don't mean to call on you, but is there anything you wanted to reflect on related to stratification?

So certainly the other piece that resonates this, the sample size, is going to play a role here as well, especially in a state with multiple minorities that are a small number in each one of the ethnicities. So this is going to be a challenging thing and a work in progress as we go there. Because of that, I think I would rather start out with a stratification standpoint as opposed to a, measuring what percentage of time you're referring from, standpoint just to get the crawl/walk/run type of process where you start learning what this data looks like and then move on from there.

Thanks, that's really helpful.

Well, why don't we move on to the next slide? You'll have an opportunity – oh, did somebody want to say something?

Okay, Eunice, we can go on to the next slide.

So now we're interested in feedback about other considerations in the Health Home Core Set, like opportunities for measure development, measure testing or refinement, methodology considerations, or other considerations for the future. This ties back to some of the conversations we were having before the break about the measure we were considering as well as the conversation about gaps. So this is a great opportunity to tie together kind of the loose threads that might have come through your mind over the last few hours and any other thoughts you have about other considerations for strengthening in the Health Home Core Set.

Amy?

Yes, thank you. This is Amy Houtrow. This is more about our process here, but I found it much more challenging to be so disconnected from the committee by not being able to see people's faces on the screen and engage, as we've really been kind of set up in this system here where there's this like sometimes multiple layers that are barriers to

engagement. I think long term that's not helpful for our processes and may in part be why we only have one thing that we're asked to look at today. I don't know, but it just doesn't feel the process that we're going through is connecting us enough as a Workgroup. I don't know if anyone else feels that way, but it just has felt harder for me to feel connected to everyone.

Do other people have other thoughts about that?

Pam and Linette, next?

I would agree. I really appreciate having the video conferencing on the day job, so to speak. I think it makes a lot of difference to how people engage.

I agree with that.

Well, thank you for that. I think we're also trying to figure out whether next year maybe we can do this in person. I know that where we are, we still have a tremendous amount of COVID outbreaks; and we've had some bandwidth issues with Internet and Wi-Fi for videos. I think that's the reason why we have not done video, but we will certainly consider that for the future and appreciate the feedback. So we will certainly consider that for how we can improve our process and try and connect people more. So thank you for that feedback.

This is Pam and I completely understand because there's a lot of meetings, I have with health homes where I have over 100 people; and video just doesn't work out. Especially in our more rural parts of the state, we don't have the high-speed Internet to allow, to accommodate for that.

Part of, I think, the reason maybe why there was only one measure for consideration, we went through this process last year and talked about several measures and made some changes. For me, it was maybe a fear of changing measures that are used too frequently because it adds to the burden of measuring. It also doesn't allow you to track over time doing that. So that, I think, is one reason personally why I didn't add a measure to consider. I do think the measures maybe we considered last year maybe could be included maybe in the future.

So one of the things that we do in Iowa when we're picking measures for something outside of health home, we continue to keep those measures in the rotation and bring them up – especially if there's a lot of interest in that measure – because maybe that year wasn't the right time, but maybe now is the right time. So I don't know necessarily what that looks like, but that's something that we do when we have our process for picking measures. I don't know if that's helpful, but that's kind of the space I was at for this.

Yeah, that's actually a really helpful point. I think we also looked it as an opportunity for creating a little bit of stability in the Health Home Core Set for the next year or two and giving states and programs an opportunity to report on the measures that are already in the Core Set, and think also about some of these future considerations, like

stratification, ways to build additional capacity. So that's probably more of kind of a 20/20 hindsight of having one measure, having an opportunity for this very robust conversation about gaps and thinking about where we go from here. So I appreciate all the different perspectives being shared. Thank you.

Kim Elliott?

Hi, I think one of the things that continues to be a challenge for all of us and maybe a little bit of a barrier as well is there are a lot of effective measures out there, a lot of good measures. With Medicaid, some of the measures aren't designed for a Medicaid program; so they're harder for us as a Workgroup to consider as a possible measure for the health home work.

So maybe thinking through or having discussions with developers and maybe some testing of some measures that may make sense for this particular program would make a lot of sense and see if there's any way that they can expand that beyond just the Medicare population or a commercial population. Because if we look at the people that are served in this program, a lot of the things do align much more closely with the Medicare program. So maybe if there's a way to look at it a little bit differently so that these measures may be more applicable to Medicaid as well – just a thought.

Thanks, Kim.

Libby?

I got stuck on mute.

I also just wanted to – I agree with a lot of the things that have been said so far and wanted to kind of echo something that came up last year. I think there was kind of a day when there was a discussion, especially around adding FUM, if I think a lot of us expressed that it would be really great if we could almost have it conditional like, yes, we'll add FUM conditional on removal of the IET so that – I forget who mentioned this earlier, but someone kind of said the notion of like it's hard to focus on too many things at once.

So I think one of the things that was particularly – or kind of in my mind in terms of thinking toward suggesting measures is recognizing that the system doesn't really necessarily allow for like swapping measures or those sort of paired in and out of measures. So I think especially when we're thinking about it at a program level and not wanting states to have to, or programmers to be overwhelmed with a lot of new measures every year, especially when it's not necessarily assumed that any of those measures are going to be removed. It kind of gives me pause before suggesting measures if I'm not sure how it will fit into the kind of like order spectrum.

The other thing that I was just sort of thinking through – and I'm not totally sure, this is a very recent thought. But I found the discussion around gaps and what we'd like to see in the future to be really valuable, and I'm almost curious about potentially like moving some of that discussion earlier because I think it would maybe help spur the thought

process of like what measures would be good to add and would be something in common across state programs.

I think one of the most useful aspects of this meeting has been that discussion around what are the gaps and what would be helpful in the future and things like that. I was wondering if having that discussion before the measure suggestion period would help kind of spur either more additions or more suggestions for removal or something. I'm not sure, but those are my thoughts.

It's a great point. Actually, it's something that I think now that we've had this very robust conversation about gaps -- which is actually a nice part of thinking more forward as opposed to having so many measures to review and so many measures to decide on and thinking about what does the future of the Core Set look like with new measures/removal of measures – I think now we've had this really big-picture conversation that ties in with some of these elements of strengthening the Health Home Core Set, we'll be able to take that list from all of you, synthesize it, and bring it back to the orientation meeting next year. And that will launch the Call for Measures.

So really be thinking a little bit more about what are the gaps that have been identified from this year's Workgroup. And it may be that for some of these, there aren't any measures or they're just measure concepts at this point. I think the reason why we have this list here on this slide is thinking about for some of these measure concepts – you know, with Hepatitis C, that's a great one, Fran where you said and I think we echoed, "I don't think there's a measure for it." Maybe it wasn't you; maybe it was someone else.

So that might be something that goes on the list for should there be measure development on a Hepatitis C measure. Maybe not – maybe this is something that's most important in a certain state for certain populations, but at least we'll have had that conversation; and we can put that out there. I think measure testing and refinement – there are probably some measures that we were talking about, I think, that come up today that exist, but maybe not quite right for the health home program. So be thinking about that.

I think one of the things we're thinking about with the Core Set relative is I think Child and Adult will also move into this format as well is thinking that maybe there are some important domains – drivers of health, social determinants of health – being an example where we know this is important. It's something that we'd like to have in a Core Set, but the measures have not been fully developed, certainly not tested in Medicaid and CHIP. So thinking through how a Core Set process might actually complete that cycle of identifying measures/measure concepts that need development/testing/refinements and not just having this be a process or a forum in which existing measures are recommended for removal/for addition, but also thinking a little bit more about to strengthen the Core Sets more generally.

So I think that's kind of the way we're thinking about it going forward and why I thought personally, the conversation about gaps was so helpful. Even the way the conversation about the follow-up ED measure was framed today in terms of what some of the – is it

strategic, is it actionable, what are the methodological issues? So lots of good conversation about that as well today.

Any thoughts tying together about measure development/measure testing/refinements or methodological considerations before we move on to the final reflections – which you all have already started, so you're ahead here. But just wondering before we move on, are there any other topics that you wanted to raise?

Fran, it looks like you have your hand raised again.

Yeah, I would love to hear from the folks in health homes, the people on the ground actually doing this and reporting and seeing what is useful to them, in the sense of how can we leverage their expertise to find the sort of sweet spot for health homes. I don't know how that is part of the measure development process; but if we could hear from the actual actors, that would be helpful to me. I'm always thinking about provider burdens, and that's just something to consider. I had another thought, but it's gone away. So I'm going to stop, thanks.

Oh! I remember now. You know how we talked about how it hasn't been tested in a state. Is there any appetite for actually incentivizing a state to report on the measure?

To report on the measure or to test the measure?

I'm sorry, to test the measure.

It's a good question. I'd love to hear more, and we'll certainly think about what that might look like.

You know, states are strapped for resources; and so that may be a useful way to leverage their expertise and focus.

That's good to hear, thank you.

Karolina?

So Fran's comment about hearing from health home providers made me think about something – made me kind of realize that I should share what I'm thinking here, which is that you know the difference between the Health Home Core Set as an evaluation. Basically, I think we have a very strong Health Home Core Set, which is a tool for evaluation of the entire program run by the state.

But there is a difference between this tool being used by providers for quality improvement, and especially you have a lot of measures now that are part of this Health Home Core Set are follow-up measures, right? We'll update you next 7 days follow up or 30 days follow up after certain events, which the measure itself is not a tool for quality improvement of a follow-up visit. All that information is just retrospective; it's too late. So I would love to hear from providers too about like what kind of information do they need to actually improve on these measures? Because knowing the rate is not enough to improve.

Linette, did you want to speak to that or something else?

Oops, sorry, I wanted to reply to the previous comment about potentially incentivizing states to pilot measures. Actually, we've talked a fair amount about using the T-MSIS analytic files. An alternative way to maybe pilot some of these measures would be to say, have Mathematica run these measures using the TAF and see what happens.

Because I know certainly one of the things that being at the state Medicaid, there is so much going on and so many different pieces in play all the time that doing something new often feels challenging, just because there's so many new things that get proposed all the time it seems like. But then also in some of the data analytic spaces – I know in California we're talking about it a lot. I imagine it's true of other states. It is hard to hire people in this. One, on the private side they'll pay more or appear to pay more or have better benefits or what have you. So getting some of these positions filled that would otherwise do some of this work can be challenging, and so we have to prioritize the work we're doing to that which is immediately required.

But if Mathematica or CMS were to fund Mathematica or somebody like that to use the TAF to test the measures, share it back with states, and say does this make sense, get feedback. That might be a really nice way to kind of do this testing issue because we run up against it on the main Core Set conversation as well. Sorry, that was the light bulb that went off as folks were talking, so thanks.

Well, Linette it's a very bright bulb because I think you might have been part of some of that with the 416 pilot that we did. We've also been doing a pilot of eight measures that are in Child and Adult. That has done really well; we've learned a tremendous amount. I think, Jim, Wyoming is involved; and your team has been part of that. So we're learning a lot. We also are really trying kind of think forward to how we might do this with stratification as well. So it's a great idea.

We're also thinking about maybe there are ways to test some high-priority measures that could be constructed in TAF. So very much that is part of conversations that we have with CMS, CMS has with us. So any suggestions that folks have, please do think about that because I think it is a really important way that we can support states and learn and really develop and refine measures for the Core Set.

So thank you.

Yeah, that would be great. Like in particular, for example, there are measures of the Core Set and then there was the measure proposed here that there was, I think, a large consensus. We haven't seen enough states do enough with it to feel comfortable moving it forward. Like those measures specifically that were proposed, and that was kind of the response, it would be really cool if you could take the TAF and run it and then we can say – and then take that back.

I know a lot of the work so far has been with things that we're already doing. But going into the states for the measures that we aren't already doing and then using that as a

way to essentially test it with states, and then we have that information next time we have the conversation next year for the Core Set. I mean that would be just amazing.

Yeah, so I've actually been thinking a lot about this and how we might prioritize. Because I think it's a lot of work to do this, okay? Working with TAF is a lot of work.

I know.

And it's a lot of work for states to look at it, right? And every one of you knows this; anytime you get a new measure, like Jim said, it blows your brains out. You have to think about some of these measures, like the measure we talked about today. So for me, it seems like the first test is, is this a strategic priority and actionable? If it passes that test, then is it something that we want to test to see if it meets in the future minimum technical feasibility requirements.

I am not sure I heard enough today to say that the ED visit we reviewed – and I would love to hear other people's feedback if you disagree with me – but I don't think I heard enough to say that measure is a strategic priority and actionable. Because I thought there were too many questions about the way it was designed and what's in the numerator, what's in the denominator. Some of that is very fundamental to being able to calculate a measure. So I wasn't 100% certain that I heard that it was a strategic priority and actionable. But if I have misheard, people should speak up and disagree with me. But that's the way I would see this test going.

I think you were referring, Linette, to the conversation we had about some drivers of health measures where I think there was no doubt that people thought that they were very important measures from a strategic and actionability point of view, but they weren't specified fully and needed to be tested. That's a whole other process. But to me, that's the first test – is it has to be a measure that if it could be feasible and viable, everybody would think it's really important to be in the Core Set – or at least 67%, two-thirds.

Dee, I think you're next.

Yes, so you just talked about actionability. I think Fran was talking about and Karolina was talking about what do the providers need. I think one of the things that I shared about we do surveys of the health homes, and they're telling us they want actionable data, things that they can do. Sending them data that is just nice to know and good to know but doesn't really give them anything to do about making a difference is not something that's helpful to them.

So as we focus on measures, the ones that have small sample size and don't include all the health home members in a health home program, while they might be good from a historical view or a top-down view, they are not helpful to the providers. Because the providers want to know who has a care gap; and if they want part of the sample size, they're not getting everybody who has that potential care gap. We've designed our care gaps to show them everybody who has a care gap, regardless of whether they were in the sample size or not. So that's one consideration.

The other thing is when you think about, is it actionable, can it go in a standard format? But one thing -- because I know most of you are sitting in a single state and looking at what you do in your state – but one thing that's problematic for all providers is that they don't have standard reporting. They have different reporting from different managed care organizations, different reporting from different organizations. If we're going to *give* them actionable data, we need to do it in a standardized way. We're setting up the standardized Core Set, which very helpful because it's standard across all states.

Is it possible for us to test sending data that is actionable to a health home in a standard template format that then would be adopted by all of the programs in all of the states, rather than each state doing something different.

Jim, did you have another question?

I took the mute button off. Actually, while I was waiting there, it slipped my mind. I'll come back to it if I think about it again, sorry.

No problem.

Well, maybe we should go on to the next slide. We have already started on reflections and feedback, so why don't we go on?

Okay, so here's the agenda for this part. We're going to recap the Workgroup recommendations. We'd like your feedback on technical assistance to strengthen Health Home Core Set reporting, also feedback on the 2023 Health Home Core Set Annual Review process and opportunities to improve next year's review. That also ties in with preparing for the 2024 Health Home Core Set Annual Review.

So first of all I think as all of you know, we had one measure for addition that we considered; and that measure was not recommended for addition to the Health Home Core Set. So I guess maybe what we could do is move on to other kinds of feedback.

We've already gotten a lot, so thank you for all your feedback so far. I'd just like to open it up for any other feedback that anyone has about technical assistance that might be helpful to start off with.

Yes, this is Jim. I remembered, as always happens. So my comment was going to be is that I think as we look forward toward new measures, by the time people show up at the emergency room it's already in some sense a failure. So I think really trying to work on, again, starting to use some of the clinical data in a way that makes sure that they're getting the preventative care; that their blood pressure is under control; their diabetes is under control; that their mental health conditions are under control.

Just to say, well, we did a follow up after the emergency room, that – I always sort of felt like what could I have done to have prevented my patient from going to the ER? I know at these early stages that's an easier one because it's got an ER code. We have ADT notifications now in our HIE. So trying to think downstream to when you talk about more actionable, we know about vaccines; we know about colorectal cancer screening. But I

think it would be nice to start focusing in on some of those other measures that you are achieving your clinical goals and reducing risk. That was what I was going to put out.

Thanks, Jim.

I know we're getting toward the end of the day here, at least for some of us. And I know it's been a while that people have been on the phone with each other, but any other feedback on technical assistance? Are there issues related to data collection and reporting or other topics that CMS can provide TA to health home programs?

Pam?

One of the things that we've been trying to do in Iowa that it would be nice to have help on, and it's around creating actionable data that connects us to those Health Home Core Set reports. So for example, the ADT was mentioned. We have that in Iowa. We're getting those, the reports; and we use the Health Home Core Set measures to determine are we reducing the all-cause readmissions from that. And what are some other maybe measures that aren't part of the Health Home Core Set, but what are those things that are being done that affect the Health Home Core Set reporting. I think that would be a huge win for us and are we on the right road when we're doing some of those things.

So are you suggesting that something like a learning collaborative or affinity group might be of interest in terms of understanding the measures, use of the measures, sharing across states about how the measures are being used to improve quality?

Well, I think a workgroup would be great; but I'm thinking more about what are those measures that we're using internally that affect the Health Home Core Set measures. So for example, we do look at our ten highest costs or our ten highest utilizers, and then do a root cause analysis to figure out what's going on. We also look at our top ten diagnoses for ED utilization and hospitalization, so we can do some evidence-based training around that. And then looking to see did we affect the Health Home Core Set measure, did that measure improve?

So what are those things that we could be doing that would help improve that? So I guess that's a little bit different than helping strengthen how we report but more technical assistance around how we maybe improve those measures.

Thank you, that's great. Any other technical assistance options or suggestions?

This is Fran. Just in terms of learning collaboratives or working groups, they're great; but they're hard to fit into the day. I think you've seen one Medicaid program, you've seen one Medicaid program. And I've found that individual State TA is often more – can be more useful at times. So at least from the Maine perspective.

That's very helpful, thank you.

All right, well why don't we move on to feedback on our process and logistics for the Health Home Core Set Annual Review. Any suggestions on how we could improve the

process, especially as we prepare for next year's review of the 2024 Health Home Core Set. So any feedback on the meetings, the materials that our team prepared and distributed to the Workgroup, the meeting platform? Anything else that comes to mind, we'd love your feedback at this point.

Dee?

Thank you, I would like to see if a measure is being recommended for addition, is there an alternative measure that's being suggested for deletion -- was that a consideration.

Okay, that's good to know. We can certainly put that in the process next year to think about that as part of the process. I think if you know that CMS is the one that ultimately decides in terms of the additions and the removals, but I think I hear what you're saying from the standpoint of a steady state in the number of measures from parsimony.

Well, that's not necessarily – it's just when they do the screening, it's on the form when you're saying I'm recommend this. Maybe a question that says, "Did you consider an existing measure that is closely related or could otherwise be removed by adding this one?" And if so, complete the removal form so that people are giving that critical thought to that, compare and contrast, and keeping it at kind of a steady state – to that point as well.

Okay, thank you.

David?

Similar, I agree with all of her comments; but also from the keeping the total number of measures down as well. I've always struggled with when you're separating the additions and deletions, a lot of times how I feel about adding or deleting it depends on the complementary side of that. If I know that we're going to delete one, then I'm more likely to add one; but at the same way, I don't want to assume I’m going vote for deletion thinking we're going to add one, and the one that I thought was going to be added doesn't get. So some way to kind of link similar measures rather than looking at them in isolation because a lot of times they depend on each other, especially when you're talking about deleting one measure and replacing it with an overlapping measure. So I know you're wanting these things to stand on their own merit, but a lot of times they're very inter-related. So I'm not quite sure how you go about that.

Yeah, we've had several examples where that's come up with the Child and Adult Core Set measures. I think we had two situations this year, and we've had them in past years as well. So we do talk about the measures together, and then we vote on the addition before the deletion for exactly the reason that you're mentioning – that if the measure is not added, you wouldn't want to delete a measure before you know whether a complementary or substitutable measure has been added. So we have – I think we've gotten pretty good at that, of trying to pair the measures, talk about them together, pros and cons, and then do the voting so addition comes before removal.

Other suggestions of how we can improve our process for next year?

Pam?

I thought it was great. I don't really have feedback on improvements, but I thought it was great to be able to talk through the measure and talk on additional detail around what are some things that we can do in the future around measures? What are some barriers to measurement, including how some of the measures are reported for Adult and Child Core measures and how they can be used. So I appreciate the format of today, the overview. That's my feedback, sorry.

Thanks, Pam, really helpful.

Any other comments before we move into public comment? I know we do have one public comment queued up at least. Any other thoughts about next year's review – any improvements we could make for this year?

This is Kim. I think this is a good format. I like the in person probably more. But I find this to be very effective, and it is a big timesaver with the travel and all. But one of the things I was thinking about when we talked about the barriers in that section of the program is to maybe think about also adding how different states resolved some of the barriers that we are discussing because all state Medicaid programs are very creative and have a lot of work that they do to really resolve barriers and improve data collection, improve reporting. So maybe if we could just add a little bullet in there about how they may have resolved some of the issues for reporting some of the measures because I think that would be a good opportunity for all states to kind of hear and see if it might work for their program.

Thanks, Kim.

All right, any other comments before we move to the next slide?

Okay, next slide, please.

So now we would like to open it up for public comment. We invite any comments from the public on measure gaps, future directions for the Health Home Core Set, opportunities to provide technical assistance to strengthen Health Home Core Set reporting, any feedback you have on the review process or any other topic of interest? Please raise your hand if you wish to speak, and we'll call on you.

I think Amy Sutton.

Derek, can you unmute Amy?

Hello, I'm Amy Sutton. I'm the Quality Coordinator for the Bureau of Medical Services, Medicaid. And we just integrated CHIP as of 7/1/22. Several comments I have for our health homes, for initial health homes. It is for the individuals with chronic depression and at risk of Hepatitis B and C. So they all get screened for Hepatitis – for the risk of Hepatitis, let me rephrase that, I'm sorry. We have two more follow up measures for it, but we did not get much luck from our data warehouse obtaining the data because it's not required. We have our health home enrollment broker, who requires like 33 or 35

mandatory results. One is the Hepatitis risk screening; one is blood pressure control. We get those from them because they're more accurate than what we get from the data warehouse because they're not required for billing.

That's the big worry I have for some of these measures is they're not – some of the codes are not required for billing. We're hoping to push it that way; but right now, there is none that we are aware of. I'd like to know if anybody else has that kind of gap and how they deal with it.

Thanks, Amy. I'm not sure you mentioned you're from West Virginia; but Amy is from West Virginia. So thank you for your comments. Do you have other comments, or did you want to see if anybody on the Workgroup has anything to respond to?

I would like to – like I said, some of the things that we'd like to see do not get coded on claims. So when we pull the measures administratively, we don't see them. I hate to say how small our group is, but we can't do claim review, or rather medical record review, rather.

Thanks, Amy. Does anybody have anything they wanted to respond to Amy's comments?

Kim, you have your hand raised.

Well, Amy I'm not sure the group has much to add to what you said. We really appreciate the comments. Did you have other comments about some of the measurement issues or comments about the conversation today?

I'm sure it's probably things other people are thinking about, but chart reviews are really hard on us for health homes. Our MCOs do their chart reviews for the child and adult quality measures, but they don't specialize it to the health homes. And that's some of the contracting, but it's really – we don't feel comfortable reporting on something we get 5% with and the MCOs get 50% with because they're actually able to look at the charts. I'd really like you all to consider the measures that have the chart reviews for smaller states like us in promoting new measures.

Okay, that's a helpful comment.

Other comments?

Do we have anyone else queued up for public comment?

Amy thank you so much for sharing your thoughts. All right, so maybe we should turn to the next slide then.

All right, so before we adjourn, I'd like to briefly discuss the next steps in the review process.

Next slide.

This graphic is a visual representation of the milestones for the review process beginning with the orientation meeting on February 22nd, the Call for Measures, and then reconvening for the Voting Meeting today. We really appreciate everybody's time today. So now our next steps are that we will be developing a report based on the recommendations of the Workgroup. The report will then be made available for public comment. We'll send an e-mail announcement when the Draft Report has been posted for public comment.

The Final Report, along with additional stakeholder input, will inform CMS's update to the 2023 Health Home Core Set, which will be released by December 31, 2022.

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.

Before we adjourn, I'd like to invite our Co-Chairs, Fran and Kim to share any thoughts or remarks they'd like to share.

Fran, do you want to go first?

Sure, I just want to thank everybody. That was amazing. That really was very productive, and I appreciate everybody's engagement and just feel very honored to be part of this really thoughtful and committed group. So thank you all. I particularly liked the emphasis on actionable data because there's folks out in the health homes who need this information to take the best care of their members that they can and getting it too late isn't particularly useful.

I'll turn it over to Kim now.

Thank you, Fran. I appreciate it.

So I think this was a very productive meeting again today. I just really value all of the feedback that everybody that participated in the Workgroup brings to the table. Everybody has a little different perspective, different thought process, which I think really just comes out with the best outcomes from the meeting, the best recommendations, such as this case where we decided against adding, or recommending a new measure to the set. I do want to thank Mathematica, CMS, CMCS, and everyone else that participated.

I think the discussion gap was very informative, such as the technical assistance, the affinity groups, et cetera. Again, thanks, everybody, for a really good and productive meeting. Sorry, I've got something that's tickling my throat. I think the ideas of health promotion – such as annual PCP visits, weight management – all of those things that preventative health and how important that is to really achieving some of the things that we are currently measuring make a lot of sense. So this was a particularly good and valuable discussion. Thank you, everyone.

Thank you so much, Fran and Kim, for being our Co-Chairs.

Thank you all for your comments today. I thought it was a very, very productive conversation particularly focused on some thinking about the future of the Core Sets, how to think about gaps. Very much appreciated everybody's focus on that.

With that, next slide please.

Thank you for attending and for your engaged discussion and feedback. This meeting is now adjourned.