Medicaid Health Home Core Set Stakeholder Workgroup: 2022 Annual Review Voting Meeting Transcript Day 1: August 17, 2021, 11:00 am – 4:00 PM ET

Hi everyone and welcome to day one of the 2022 Medicaid Health Home Core Set Stakeholder Workgroup Voting Meeting. My name is Patricia Rowan and I am a senior researcher here at Mathematica. Before we get started, I'd like to cover a few housekeeping items.

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All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for Workgroup members and the public to make comments. To make a comment, please use the 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 have joined us today using the mobile app will need to open the participant panel by tapping the participant icon, and the raise hand icon will appear at the bottom of your screen. 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.

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

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Now I will turn it over to Margo Rosenbach.

Thank you, Tricia. And 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. It's my pleasure to welcome you to the voting meeting for the first ever stakeholder review of the Medicaid Health Home Core Set. Whether you are 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 measures suggested for addition to or removal from the Health Home Core Set. Second, the Workgroup will vote to recommend updates to the Health Home Core Set. We'll also discuss gap areas and areas for future measure development. Finally, we'll provide opportunities for public comment throughout the two-day meeting.

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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'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 our team is still 100-percent remote. I hope everyone will be patient as we do our best to navigate through any technology challenges that we encounter.

Some of you may be wondering why we are not using video for this meeting. We've 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 member, however, you are 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. Please keep this in mind during the discussion and voting.

Second, we know that spending several hours a day in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning from breaks so that we can have everyone present for the discussion and voting on the portfolio of measures before us the next two days. Finally, we want to make sure that all Workgroup members who wish to speak may do so. The WebEx platform we are using will enable you to unmute yourself when you want to make a comment or ask a question. If you find that you are unable to jump into the conversation, please raise your hand or contact us using the Q&A feature and we'll make sure that 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. Now I'd like to turn to our Workgroup co-chairs Fran Jensen and Kim Elliott to offer their welcome remarks. Fran, would you like to go first?

Sure. Can you hear me okay?

Yes, we can.

Great. Well, thanks everyone for joining. This is quite the challenge, I realize, going through all the materials, but I'm really looking forward to it. And, again, appreciate everyone's input. While I am not supposed to bring my own state involved, I just want to underscore how important this work is and how it's really a focus on improvement. When I was at CMS, I was involved with many states, rolling out this innovative program. Now I'm in Maine and seeing the sort of fruits of our labor. We have three health homes here. And just bringing that lens in the sense of watching the evolution of the program is really rewarding for me and I really am looking forward to people's input, learning from their experiences but also their just general knowledge of the importance of measurement as a tool for improvement. And I think the health home really speaks to the importance of bringing a multidisciplinary team to the care of beneficiaries and that should be reflected, hopefully, in the measures that we recommend, either removing or adding or future directions. So, with that, again, I'm looking forward to the discussion and learning from you all and seeing what we can do to improve the program. Margo, I'll turn it back to you, or am I turning it to Kim?

Kim is next. Hi, Kim.

Thank you, Margo and Fran. This is Kim. And, again, I would reiterate what Fran said. This is really an important endeavor. I don't think that there are too many things from a quality perspective or driving quality improvement that are more important than identifying and selecting appropriate measures that are really going to show the quality of care and really drive improvement in the programs that we're trying to do the measurement for. So, to do so, I think selecting the measures is really important and I think everybody's individual expertise, background, experience, education is really going to be an important factor in applying all of that knowledge to understanding whether these measures are feasible, usable, whether the measures can be used by states to really drive improvement in the health home services that are being provided, and really ultimately to improve the healthcare quality and service delivery for those populations served under the health home waivers. With that, I think I will turn it back to Tricia.

Yeah, thank you so much, Kim and Fran. We really appreciate your willingness to serve as co-chairs and your opening remarks.

So, next slide, please.

So, now we'd like to introduce the Workgroup members and any disclosures of interest. We'll also use this time for a brief icebreaker. So, as you introduce yourself, I'd like to ask that you share your name, your organization, and your favorite memory of the summer so far.

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To ensure the integrity of the review process, we ask to 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 the current Health Home Core Set measures or the new measures that will be reviewed by the Workgroup. During introductions, members are asked to disclose any interests related to the existing or new measures that will be reviewed by the Workgroup.

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When we go through the roll call, we ask that Workgroup members raise their hand. When their name is called, we will unmute you so you can say hello, share any disclosures you may have or indicate that you have nothing to disclose. Please share your favorite summer memory as part of our icebreaker. When you're done with your disclosure, please mute yourself in the platform and lower your hand. This will allow you to mute and unmute yourself as you'd 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 re-enter the platform or find you've been muted by the host due to background noise, just raise your hand and we'll unmute you.

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On this slide, we've listed the Workgroup members in alphabetical order by their last name. When I call your name, just as a reminder, please use the raise your hand feature in the WebEx platform and we'll unmute your line and you can introduce yourself. So, Fran, starting with you, would you mind starting to indicate whether you have any disclosures and share a favorite summer memory? Fran, you should be able to unmute your line.

Okay. Great. Got it now. I have no disclosures. I'm the Medical Director of MaineCare, which is the Medicaid state agency in Maine. My favorite summer memory probably is what I did this weekend. I sailed with a friend overnight up along the coast of Maine, in Merrymeeting Bay up to a little past Boothbay Harbor. And it was amazing.

That sounds lovely. Kim Elliott.

Kim Elliott. I work for Health Services Advisory Group, which is an external quality review organization. And I do not have any disclosures. My favorite summer memory would probably be when my children were little, traveling across the country, going to as many of the national parks as we could, and it was just a really fabulous time.

Thanks. David.

David Basel. Director of Quality. I'm a peds physician in clinical informatics. We work out of South Dakota, Minnesota, Nebraska, and Iowa. I do not have any conflicts. And I just came back from a week-long cycling tour in Montana. So, feeling tired and strong.

Thanks. Dee Brown.

Hi. I'm Dee Brown. I have no disclosures. I am the National Vice President for Community Integrated Care for United HealthCare. I oversee home health programs in Missouri, New York, Minnesota, Washington, and California. I am very happy with my last weekend because I got to see all four of my grandchildren this last weekend. So, that's my favorite summer memory.

James Bush.

Yeah, this is Jim Bush. I'm an internist and Wyoming's Medicaid Medical Director. I have no disclosures. And my favorite memory of this summer was, hands down, getting my daughter married.

Congratulations to you all. Karolina Craft.

Hi. Can you hear me?

Yes, we can.

Thank you. Hi, my name is Karolina Craft. I work at the Minnesota Department of Human Services. I am the quality manager there. In terms of disclosures, I have nothing to disclose but I was asked to say that to the best of my knowledge participating in this Workgroup would not benefit adversely affect my interest. In terms of my favorite summer memory, I grew up in Poland and my family lives in Poland, and because of COVID, I couldn't see them for a long time. So, my favorite memory is that I got to see them this summer.

Great. Samantha.

I work at the State of Kansas Department of Health & Environment. I have no disclosures. And I think my favorite summer memory is this summer my family is building a new house. So, that's been exciting.

Great. Thanks. Pamela Lester.

Hello. I have no disclosures. I have a nursing background with a Master's in Healthcare Quality. I manage the health home program here at Iowa Medicaid. And my favorite summer memory, the jury is still out on this summer as my vacation is next week in Colorado to torture my husband hiking. So, hopefully that will be my best summer memory.

Thanks, Pamela. Elizabeth Nichols.

Hi. I'm Elizabeth, or Libby, Nichols. I have no disclosures. I work for New York State Department of Health in the Office of Quality and Patient Safety. And let's see, I got married earlier this summer, so that, for me, was definitely the high point of this summer.

Congratulations, Libby. Linette Scott.

Good morning. Linette Scott, I'm the Chief Data Officer at the Department of Healthcare Services in California, which runs our Medicaid program for the state. I have done a lot of work with Core Set measures in a variety of different ways, as well as other data activities across the department. No conflicts of interest. And for this summer, I think one of the highlights was taking our Virginia family to Alcatraz Island to see the prison. Thanks.

Great. Jon Villasurda. I do not see Jon. Jon, if you are here, could you raise your hand? Maybe while we're waiting for Jon, why don't we move on to Theresa.

Theresa Walske, Wisconsin Medicaid. I'm a policy analyst.

Theresa, I think we might have lost – or the audio cut out. Do you want to try again? Theresa, do you want to try again? Can you hear us now?

I'm sorry.

I heard you say "I'm sorry" but didn't hear anything after that. I might recommend trying to reconnect the audio. Oh, are you there? Okay. Theresa is going to try to reconnect. The last person on our Workgroup is Roderick Winstead. I do not see Roderick on the line. Roderick, if you are here, can you raise your hand? All right. Well, we will wait to see if Jon or Roderick join us, and to give Theresa an opportunity to reconnect. Just as a reminder, I would suggest, if you have to reconnect to the platform, to use the call me feature. That might help if you're having any headset or local Wi-Fi issues as well.

All right. Why don't we go to the next slide and then we'll come back.

All right. So, we're also joined today by federal liaisons who are non-voting members of the Workgroup. I will read the names of the agencies represented but not do an individual roll call. So, we have representation from the Administration for Children and Families, the Administration for Community Living, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Center for Clinical Standards and Quality at CMS, and the Substance Abuse and Mental Health Services Administration.

Federal liaisons, if you have questions or contributions during the Workgroup discussion, please raise your hand and we will unmute you. I would also like to take the

opportunity to thank our colleagues in the Disabled and Elderly Health Programs Group and the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services, and also to the measure stewards who are attending and are available to answer questions about their measures.

Before I move on, let me see if Theresa, if your audio is better now. Okay. I see you said in the Q&A that you can hear us but you're having some headset issues. So, that's fine. Just let us know when you think things are resolved and we can try again later. So, great.

Now I'd like to spend a few minutes providing some context for today's measure review since this is the first year of this process.

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CMS established the Health Home Core Set of Quality Measures in January 2013 for the purpose of ongoing monitoring and evaluation across health home programs, and states reported home health measures for the first time for federal fiscal year 2013 and recently completed reporting for federal fiscal year 2019. The federal fiscal year 2020 reporting cycle is currently in process and generally covers services delivered in calendar year 2019. As a condition of payment, Medicaid health home providers are required to report quality measures to the state, and the states are expected to report program-level measures to CMS. SPAs are expected to report all of the Health Home Core Set Measures, regardless of their focus area.

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This slide contains the measures on the 2021 Medicaid Health Home Core Set. There are 11 measures, including eight quality of care measures and three 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 Set. You can see from the slide that the age ranges vary and that the measures are distributed across the various health home focus areas. Finally, all but three of the Health Home Core Set measures are included in either the Child or Adult Core Set.

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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 2019. As of April 2020, 21 states have 35 approved health home programs. Some states have multiple SPAs that target different populations.

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At the time we began the Health Home Core Set review process, CMS had released performance and trending data for Health Home Core Set measures for the first time. We'd like to recap a few of the highlights as we convene over the next two days to discuss and vote on measures for addition and removal. All 35 SPAs were expected to report Health Home Core Set measures for FFY 2019 and 31 of those SPAs reported at least one measure. The other four SPAs did not submit data in time to be included in publicly-reported data.

SPAs reported a median of seven out of the ten Health Home Core Set measures in the FFY 2019 measure list. And seven of those measures were reported by at least two-thirds of the SPAs expected to report. Reporting remained consistent or increased for 24 of the 25 SPAs that were expected to report in the three years from FFY 2017 to FFY 2019. And reporting also increased for all nine measures that were included in both the FFY 2017 and FFY 2019 Health Home Core Set.

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So, this slide probably looks pretty familiar to you by now. It provides a framework for assessing measures during the discussion and voting over the next few days. 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 align with strategic priorities, and that are feasible and viable for states to implement. Conversely, the Workgroup should recommend measures for removal that are no longer considered feasible, desirable, or viable for program-level reporting in the Health Home Core Set.

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So, this visual representation of the concept of multi-level alignment of quality measures is also probably familiar to you. As we mentioned during the last meeting, CMS values alignment of quality measures across programs and levels because it can help to 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. And as you can see, aligning measures at the health home program level, the state level and the national level can help facilitate quality improvement efforts, both within and across levels.

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To help Workgroup members review the measures, we wanted to recap the criteria for recommending the addition and removal of measures. So, I'll begin with the criteria for suggesting measures for addition. On this slide, we show the criteria for meeting the minimum technical feasibility requirements. First, a measure must have detailed specifications that enable production at the program level and must have been tested or currently used in state Medicaid or CHIP programs. It must have an available data source or validated survey instrument that contains all the required data elements so

that the measure can be calculated in a consistent manner across health home programs. And the final criterion articulated by CMCS is that the measure must include technical specifications, including code sets that are provided free of charge for use in the Health Home Core Set. And the Mathematica team assessed all the suggested measures for adherence to these minimum criteria.

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Measures suggested for addition should also be actionable and align with strategic priorities in Medicaid. More specifically, when taken together with other Health Home Core Set measures, the measure should be useful for estimating the overall national quality of health care in Medicaid Health Home programs. Additionally, the measure should allow for comparative analyses of racial, ethnic, and socioeconomic disparities. Second, a measure should address a strategic priority for improving healthcare 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 health home programs.

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Some other important considerations for assessing measures for addition include whether the condition being measured is prevalent enough to ensure adequate denominators across health home programs and whether the measure is aligned with those used in other CMS programs, especially the Child and Adult Core Set. Finally, Workgroup members should consider whether all health home programs may be able to produce the measure by FFY 2024, including for all health home populations.

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When Workgroup members are considering measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. For example, we ask the Workgroup to consider whether the measure no longer makes a significant contribution to the Health Home Core Set's purpose of estimating the national quality of care, is the measure unable to be used to assess improvements in Medicaid Health Home programs, are SPAs unable to access the data needed to calculate the measure, or is the data source leading to inconsistencies across states, do the specifications and data source allow for consistent calculations across health home programs or is there another measure that's better aligned with CMS programs. This is not a comprehensive list of the reasons for removal but just a few key considerations for the Workgroup to consider.

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This slide lists the eight measures that will be reviewed and voted on during the voting meeting. This slide includes the measure steward, the 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 Workgroup will begin with assessing three measures suggested for removal from the Health Home Core Set. These are the Ambulatory Care: Emergency Department Visits, or AMB measure, which has also been recommended for removal from the 2022 Child Core Set. The Screening for Depression and Follow-Up Plan, or CDF measure, and the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, or IET measure.

Then we will discuss five measures suggested for addition to the Health Home Core Set. These are Follow-Up After Emergency Department Visits for Mental Illness. This measure is in the Adult Core Set and was recommended for addition to the 2022 Child Core Set. The Asthma Medication Ratio measure, which is currently on both the Child and Adult Core Set. The Comprehensive Diabetes Care: Hemoglobin A1c Poor Control greater than 9.0 percent; this measure is on the Adult Core Set. Colorectal Cancer Screening, which has been recommended for addition to the 2022 Adult Core Set. And finally, the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, Health Plan Survey. For this measure, we'll be discussing and voting on both the child and adult versions of the survey. And the CAHPS surveys are also on the Child and Adult Core Sets.

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So, we have covered a lot of ground. I'd like to pause here and provide an opportunity for questions or comments from Workgroup members. Remember, if you'd like to speak, please use the raise your hand feature and we will call on you in turn. Samantha, I see you have your hand raised. Is that just from before or if you have a question or comment at this point? Okay. Your hand went down, I'm assuming maybe. Go ahead. All right. Any other questions or comments at this point? Okay.

Before we move on to the next component of our agenda, let me just quick ask Theresa if you want to check your audio again and try to unmute and see if we can hear you. Okay. I am not hearing anything from Theresa, unfortunately. So, keep trying. Let us know if you need any help through the Q&A function. All right. I also don't see that those other Workgroup members have joined us, so I think we can move along in our agenda.

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So, I'd like to turn it over to Margo Rosenbach from Mathematica to help facilitate our discussion on the use of Health Home Core Set measures for quality improvement. Margo.

Thanks, Tricia. As Tricia mentioned, one of the criteria for assessing measures on the Health Home Core Set is whether they can be used to assess progress and improving health care delivery and outcomes among Medicaid Health Home enrollees. So, during this next part of the agenda, we'd like to spend some time hearing from Workgroup members about their experience using health home measures for quality improvement. After reflecting on the Workgroup discussion during the meeting two weeks ago, we

thought it would be helpful to hear from Workgroup members about how they use the measures in their programs. And we hope this will inform the review of measures suggested for removal and addition.

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So, this slide lists several topics to guide the Workgroup discussion. For example, what experience do you or does your state have in using the Health Home Core Set measures for quality improvement? Are different measures used for different populations or types of health home programs? Are any of the measures used to understand and address health equity or social determinants of health? And finally, do you have any other reflections on the use of Health Home Core Set measures to drive quality improvement for Medicaid health home enrollees?

To start off the conversation, we've asked a few members of the Workgroup to help get us started. We'll start with Pamela Lester followed by Elizabeth Nichols, and then Kim Elliott. And then we'll open it up to other Workgroup members to share how they use the Health Home Core Set measures. Pamela, would you like to start?

Yep. I sure can. Thanks for inviting me to talk about our use of Health Home Core measures. Our managed care organizations (MCOs) are assigned as a lead entity in the health home program and they develop performance measures. From 2015 to 2018, they were required to use all Health Home Core Set – all of the performance measures were required to be from the Health Home Core Set. In 2019, we changed that a little bit and allowed for measures to be included in the performance measures that weren't necessarily Health Home Core Set measures but were required to impact those to some degree.

So, currently, both of our MCOs have inpatient utilization, ambulatory AMB health home, so the ED utilization, the follow-up after hospitalization. So, we use seven-day. They have measures – those are the measures that are part of the Health Home Core Set. And then they have other measures such as some of the ones that are suggested, asthma medication, follow-up after ED for mental health, adherence to antipsychotics, controlling the blood pressure A1c, some things like that. But when they present those to us for approval at Medicaid, we require them to tell us how it impacts those Health Home Core measures. So, asthma medication may impact inpatient utilization or ED utilization. So, they have to identify that when they present those for approval. We also have analytics that support those Health Home Core measures, so looking down into maybe our high – what are the diagnoses for those high utilizers, whether it's ED hospitalization or high costs, and then really drilling down to figure out what processes can we improve to truly impact those Health Home Core measures.

We also share those results, Health Home Core Set results, with the health homes to really engage them in the work and have them understand the alignment and how it impacts the work that they do. Then the other thing that we do is we have a learning collaborative model. So, the MCOs have monthly webinars. We have a two-year face-

to-face which hasn't gone so well for us with COVID. And then the MCOs also provide individual technical assistance to help improve those Health Home Core measures and really impact outcomes and quality. So, that is kind of the high level of some of the things that we do with the Health Home Core measures.

Thank you. That is quite a lot and quite impressive, and I think provides really nice context for what we're going to be talking about for the next day-and-a-half. So, with that, Elizabeth, you're next.

All right. So, in New York, we, as a department of health, use quality measures as part of a number of different feedback mechanisms for the health home program. So, we provide rolling year results with an update every quarter for a suite of quality measures, including but not limited to the Health Home Core Set. And part of the goal there is that each health home can log in and look at their updated rolling year results and if they have a specific project or population that they are focusing on, they can find a quality measure that is relevant to that. So, the health homes have access to these aggregate results for use as quality improvement as needed. And the quality measures are also provided for different subpopulations, including specific programs or conditions, as well as other aspects or characteristics, so things like length of enrollment in the health home program.

We determine quality measure benchmarks using the distribution of health home results. And health homes are provided with an annual improvement target, which is ten percent of the gap between their previous rate and the benchmark. And meeting that annual improvement target is one of the factors that's considered during redesignation for our health homes. We're also working on a number of other projects to continue to provide access to quality measure results in accessible and actionable formats to the health homes, and also provide those results for members from a consumer perspective.

And I know that also our health homes and MCOs have a quality group that works together and meets regularly, and I think one of the things that they also look into is aligning what measures MCOs are interested in across many different MCOs so that the health homes can kind of winnow in and narrow down what they're focusing on. That's one of the things that they're working on right now, and I think that aligns well when we're thinking about the Core Set.

Another thing – so, anyways, that's sort of mainly what we've been doing. And, you know, there's lots more that we'd like to work on. I think one of the things that we regularly struggle with is the data lag that's inherent in providing quality measure results. And, when you take into consideration that some parts of our health home population are not necessarily static, it means that results from prior time periods might not always reflect the current health home membership. So, I think we're really interested in finding unique ways to look at measures that can provide information that's really actionable for the health home moving forward, and measures that kind of

highlight things that, you know, are really in the middle of that Venn diagram. So, that's sort of what we've been looking at.

Great. Thank you for sharing your experiences in New York. Now we'll turn to Kim. Would you share your experience working with multiple states as part of an EQRO?

Sure. And I'm talking from kind of a broader perspective, core measure sets in general. So, we do work with 18 different states as an external quality review organization. And of the ones we work with, four of them do participate in the health home or have a health home waiver. I think some of the things that our organization has really observed and had discussions with our states about is really the use and usability, and a lot of that is driven by whether they have accurate, valid, reliable data sources to be able to accurately measure, and then whether the measures can be stratified.

And the stratification tends to be a really important factor for many of the states that we work with because so many of them now are focused on social determinants of health, disparities, race, age, gender, types of issues. And some of that, of course, is used by our states to really home in on performance improvement and quality improvement initiatives, and also in their value-based payment arrangements, to really try and drive improvement in either the disparity populations or the populations as a whole. So, the data source is really important, the validity of it, how easy it is to get. Cost is always a huge factor for the states that I work with in that if they have to do medical record review or collect data from EHRs and have to set up different streams to get data in, it creates more challenges and makes it much more difficult for them to be able to use those as their performance measures.

I think that the other thing that's really important is, from a core measure set, those that align with the state's priorities are the ones that you're going to see or we see a lot more effort and ability to really take those measures on and build them and work with either their managed care organizations or providers to really drive that improvement in those rates. And also, care coordination is just such a key factor. So, any of the core measures that are impacted more strongly by the care coordination and ability to reach the members that they serve, that makes a huge difference, too, in whether they're going to really be able to drive some of these rates. So, I think the selection of the measures and how many people it really impacts, those are areas that will make a difference in whether these measures are easily picked up by the states and implemented by the states that we work with.

Thank you, Kim. So, now we'd like to open it up to other Workgroup members to share your experiences. If you have any questions or comments, please raise your hand or please just jump into the conversation right now. Dee, I see your hand raised.

Yes, thank you for sharing all of those thoughts. I think it's very important that we figure out what – and coming from an MCO, the MCOs are responsible for the Adult and Child Core Sets, so that alignment is really important. But more importantly, the last speaker who was talking about what is impactful and actionable by the care managers to really

create a result in achieving a measure set was one of the primary thoughts in my head. I see in the states that I'm managing multiple challenges with either having access to the data or having an impact on a quality measure. So, it is really important that we think about does the care manager have the ability to effectuate the change that is needed in order to close that care gap. So, I really appreciated all the callers' comments.

Thanks, Dee. Samantha, you're next.

I think the previous comments kind of stole my thunder but I did want to tie two things together, that being the notion that they should be impactful and actionable, but also that – for a state like Kansas at least, all of this, ideally, will lead to some cost savings. We had a very unfortunate experience of having a health home program several years ago that was making good progress but it wasn't doing it quickly enough. And given the political climate at the time, it went away. The legislature pulled funding.

And so one of the lessons learned for a state like Kansas was, in the second iteration of our health home, we wanted to set our sights on areas that, again, we knew we could make an impact on but that would ultimately lead hopefully to cost savings. Because if we can't demonstrate that, and I'm sure we can't be the only state out there, we're not going to be able to continue to do this good work. So, the more we can align all of these various impulses, I guess is one way to say it, the better off we're going to be. Because if we're so scattered trying to pursue cost savings in one area and making sure we're doing good quality – pursuing good quality metrics and put in efforts in that area, we're not focused. So, I think the importance of being able to focus on areas that will, again, be impactful, actionable, but also hopefully lead to some cost savings.

Thank you. Who's next? Feel free to raise your hand or just jump into the conversation. Fran.

Hi. Am I coming through?

Yes, you are.

Okay. Great. So, interesting, Maine is a fee-for-service state. So, it's interesting to hear how states are using and plans are using Health Home Core Set and Core Sets in general, and aligning those measures, which, from a provider perspective, is super important because one of my foci is burden reduction. And to your point about the data needs to be actionable, one of my statements always is data is good, information is useful. So, I always keep that in mind.

But we are starting to actually move away from one of our health homes, sort of what we call the sort of the regular health home. We're going to continue to use the behavioral health home and the opioid health home, but actually using the health home improvements into a new downside risk – yeah, downside – well upside and downside risk primary care plus model that we are calling it. So, it's morphing into a more – I

would say more robust model. And so we've used a lot of the learnings from our health home activities to, again, evolve and hopefully improve the quality of care.

We're also incorporating some of the learnings from our data collection and measurement to improve our accountable communities as well. And the highest tier of the primary care plus practices will also be in an accountable care organization. So, it's all sort of fitting together. I'm not sure if we would have been able to do that as much if we hadn't focused on aligning the measures as much as possible. So, I think we've had quite a bit of experience, but it's interesting, some of the measures talk about the plan level. And so – I can't remember which ones per se, but hopefully we can talk about that a little bit and how that would relate to a non-plan.

Fran, that's a really good point. And I think one way to think about that, and this is good for all Workgroup members to consider, is that when we look at measures that are specified for the plan level, say a HEDIS measure, for the purposes of the Core Set, we adapt them to the program level or the state level. And we work with measure stewards to make sure that we can do that effectively. So, I think it's a really good point and I think that's where that multilevel alignment graphic that Tricia was talking about that shows all the different levels and how they move up, they also kind of move down; right?

Yeah.

So, I think the goal here is to try and find measures that can be used at multiple levels and aggregated up or disaggregated down.

Yeah.

So, it's a really good point.

Okay. Great.

And Dee, it looks like you have your hand raised again.

I did. Thank you. I just wanted to comment on the one speaker from Kansas who was talking about being able to have cost savings. Because I have five states that I'm working in, it's been our experience, and I just wanted to comment on that because we do a lot of data analytics for the programs at a population health level, to note that members who are so chronically ill qualifying for health home services typically are over their premium dollar to begin with in services. And then you add on the cost of paying for health home services to those costs of healthcare services, it makes it so that it isn't cost savings.

But what we do see significantly changing is the trajectory for the members who have avoided avoidable inpatient, have avoided avoidable ER and who, though because there's cost savings inherent in those avoidance, there are additional costs for

increased outpatient services and specialty care services to close care gaps specifically because now they're getting the services that they need. And then the outpatient and pharmaceutical care costs go up. So, the total cost of care tends to either remain the same for those that remain in the program over a period of years. But that doesn't mean that there's anything incorrect about your assumption because what we're saying is it's not actually saving money but it's actually preventing furtherance of the chronic conditions, the ability for the members to get served at the right place, at the right time, in the right level of service, and have appropriate preventive services met that flatline their cost, but it doesn't reduce the costs.

So, there's not a real cost savings is what our experience has been, and this is five years of taking data in five different states. So, I do want to say that I do think that at the ACO level that was just discussed – and Minnesota also has that – I think the ability for a larger primary care practice to make that difference and do cost share savings is a possibility, but they need to be met with an increased connection with behavioral health services in order for those savings to be capitalized. So, just a bit on the financial aspect of the services we're talking about.

Dee, thank you so much for those comments. And as you were talking, I was thinking, oh, there's a Health Home Core Set measure for that and there's a Health Home Core Set measure for that, and we're going to be talking about that one later today or tomorrow. So, thank you for kind of giving that broader context about the measures, about costs, about total cost of care. I think that's just very, very helpful to hear about. David, I see you have your hand raised.

Yeah, I was going to pile into the conversation as well. With us operating both in Minnesota and South Dakota, we see kind of the sides of that. In South Dakota, we were, as a state, either skilled enough or lucky enough that our health homes actually did help the Medicaid to have some spare dollars early on that the legislature was generous enough to pile back into quality programs, to the providers in clinics. And so we got a lot of engagement and performance improvements on the health homes through that process.

And a couple points that I'll make from that journey of being pretty active at the state level as well as at the local provider level is that recurrent points I'm going to make today, is we've continuously narrowed the focus down. I think we started with 50 measures at the state level and narrowed that down considerably time and time again to try to get to what are we truly trying to focus on. And that's what I'm going to be looking for the core measures as well, as much as we can get those narrowed and focused, the better.

And the other point is that looking at the measures to see are they measuring the true program and clinical quality and thus are showing impactful data that you can change or are they more measuring the quality of the data systems that are being used to measure them. Now, the quality of the data systems itself, that's an important metric because you can't measure it if you can't improve it, certainly. But some of these hybrid

measures, in my experience, have been less impactful because you spend all of your time trying to validate the information and trying to get everybody on the same page of the information at the clinic and provider level. And I think that happens at the state level, too. Are you comparing one state's data system to another state's data system, or are you comparing one state's program and clinical quality to the other? And there's a distinction there. So, that's something I'm going to be paying a lot of attention to as the day goes on.

Yeah, thank you, David. We appreciate those perspectives and look forward to hearing your comments as we dive into some specifics. I'm curious to hear form Workgroup members, even if you've already spoken, feel free to raise your hand and speak again, about whether different measures are used for different populations or types of health home programs. I think that's something that we think about in terms of how do you construct a Health Home Core Set that really addresses the variety of populations that are being served and whether it takes a somewhat larger set of measures to reflect the diversity of the populations. So, I'd like to hear from anyone who has any comments to make about that. Fran, you look like you have your hand raised. Is that from before or do you have another comment?

I think it was before but I can make a comment.

Sure. Go for it.

I think one of the challenges, you know, is one of our health homes is – well, the behavioral health home is serious mental illness and serious mental disturbances, which separates the kids from the adults. So, I think we don't – you know, we – and some of them serve both. Some of the behavioral health homes serve both kids and adults. So, I think that's probably confusing for those organizations that sometimes aren't very large, to report on both and individually, if that makes sense.

And then for the opioid health homes we have, it's fairly limited. That's a newer health home and I think they're sort of hitting their groove now. It took a while to figure out the payment for them. So, I think they're kind of struggling with reporting. So, you have to also take in the capability and the capacity of those organizations to report. I'm not sure if that's helpful or what you're looking at but.

Well, it is. And I think it reflects something that we see in other Core Sets as well, that it does take time to ramp up, that when you bring in a new measure or, in your case, when you have a new health home, it takes time to ramp up the capacity both to collective report the measure and, of course, to use it for quality improvement. So, other Workgroup members, other comments, other reflections, any other reactions to what you've heard? Linette.

Just to echo on some of the comments a little bit. I think, Margo, you asked a question about the different SPAs or the different health home programs. I know just in terms of thinking about running the measures, so we've used our administrative data to run the

measures for our health homes programs. And the way it's been structured in California is that it's county-based. So, it's looking at things by county but then we roll it up to report for the state, for the Core Set measure reporting that happens annually. And part of it is it's just the size of the population. So, denominators may be small. And some of the measures, especially if there's not very many people that are going to be in your denominator or numerator, is – just wearing my measure calculation hat – it can be kind of hard in terms of just thinking about how to deal with it, and especially for some of the things that are smaller groups.

The other aspect, too, is that there's different kinds of health homes or SPAs, State Plan Amendments, that go for the different programs. And so you're splitting people into these different groups and you're running all the measures for both groups. But if you have a group that's related to severe mental illness and such, the measures that relate to mental illness obviously apply there. But say you have one that's focused on some of the chronic diseases like hypertension, cardiac disease, et cetera. While there may be overlap, they may have a very small number for something like substance use or mental illness because that's not the focus area of that particular SPA.

So, one of the things, because the health home program is focused so much on people who have high need and lots of care coordination needs, it is a little bit challenging looking at some of the measures, especially when they've got very much specificity. So, you just shrink your denominators and numerators and then the question becomes is it enough to be able to really draw conclusions when you see changes and trends over time. So, that's just one of the thoughts that's been going through my head as I listen to folks talking. Thanks.

Thanks, Linette. Other Workgroup members who have additional comments, reflections? Share before we break. Anyone else? Well, I really have appreciated all of the thoughts that people have shared. It's just been really helpful. I think a bit of level setting before we come back this afternoon to start reviewing the measures. And I think it's helpful for public listeners to hear about state experiences, and helpful for each other to hear about experiences. I think that will enrich the conversation later.

So, before we break – and we're giving you all a really nice, long break here – we wanted to encourage Workgroup members to be logged into the voting website and have the voting guide available when you get back because when we return from the break, we're going to practice voting and then actually dive into looking at some measures. So, I hope everyone enjoys this nice, long break. Please be back by one o'clock. We will start punctually at one o'clock. So, enjoy your break.

A lot of people are still joining us. Since we were able to take such a long break, we would like to do a quick Workgroup member roll call, just to make sure that we have everybody back with us, given that we are moving into the voting component of our meeting. So, let's see. Why don't we start at the top here? I am going to ask Workgroup members to raise your hand and unmute yourself, and just, you know, announce that you're here. So, starting with Fran, Fran Jensen.

I'm here.

Great. And Kim Elliott.

I'm here.

Great. David Basel. David, I see you on the line. Can you raise your hand so we're able to unmute you?

Present.

Yep. Great. We can hear you now. Thanks. Dee Brown.

I'm here.

Great. Jim Bush. Don't have Jim yet. Karolina Craft. Karolina, are you on the line?

Yes, I am.

Great. Samantha.

Hi. Present.

Pamela Lester.

I'm back.

Libby Nichols.

Here.

Linette Scott.

[Indiscernible]

Derek, can we unmute Linette? Linette, can we – can we make sure we hear you?

There we go. Yep. Good morning.

Great.

Afternoon. It's still morning here.

That's right. On your coast, it's still morning. Okay. I don't see Jon. Jon, if you're on, please raise your hand. And let's see, Theresa, I see you're back. Do you want to try and see if your audio connection is better this time?

Sure. I think it works now.

Yes. Hooray. We can hear you. Great. And then I also did not see Roderick. Roderick, if you're here, please raise your hand. All right. Well, hopefully folks are – will be joining us back as we get back into the business of our meeting.

Eunice, if you want to go to slide 29 for me, that would be great.

All right. Well, we'd like to spend a little time practicing and discussing the voting process that the Workgroup members will use for the rest of this afternoon's meeting and tomorrow. So, voting will take place after Workgroup discussion and public comment. And Workgroup members will vote on each measure in its specified form. For each measure for addition, a yes vote is equal to "I recommend adding the measure to the Health Home Core Set." And a no vote equals "I do not recommend adding the measure to the Health Home Core Set."

Similarly for each measure for removal, Workgroup members will vote yes or no, where yes equals "I recommend removing the measure from the Health Home Core Set" and no equals "I do not recommend removing the measure from the Health Home Core Set." For a measure to be recommended for removal from or addition to the Health Home Core Set, the yes votes need to receive two-thirds of eligible votes. And let me just pause here. It looks like Jim Bush, you've joined us again. Jim, can you just make sure we can hear you?

Can you hear me?

Yep. I can. Yep.

Yeah, sorry, I had – I met – a director needed to meet with me, so I apologize.

Understood. Understood. Thanks for joining us. All right. So, we sent a voting guide to Workgroup members last week. And I wanted to pause here just to see whether there are any questions from Workgroup members about the voting process or the threshold for a measure to be recommended before we move along to a practice vote. Linette, I see you have your hand raised. Is that from before or did you have a question about voting?

Sorry. I forgot to take it down.

That's all right. And Theresa, I see your hand is still raised. Is that from before or do you have a question?

No, I'm still practicing. So, I'll take my hand down.

Okay. All right. Great. Thanks so much. Jim, go ahead. I see your hand raised.

So, I did go in there and I said I like my waffles, but are we going to be able to vote from this side or do I have to open up the other side again?

You will have to have the – you will need to be logged on to the other site, to the voting platform, to be able to cast a vote. That site is compatible with mobile devices if you've got, you know, a phone or a tablet nearby you want to use, or you should be able to toggle back and forth between the WebEx and the polling platform.

Okay. Then I just need to go find that link again unless you all can resend it real quick so it's at the top.

Yeah, we can probably have someone on our team just reforward it.

Great. Thank you.

Yep. Are there other questions about voting? Samantha.

Yes. It'd just be helpful if you could resend that link to all of us, or at least me.

Yeah. Yeah, we can do that.

Where you are with Poll Everywhere, when it says PollEV.com/username, when I put in my username, it's not – which is supposed to be my email – it's not allowing me to join. Or are we supposed to be in Core Set Review?

Yep. So, where it has the forward slash, you want to put in "CoreSetReview, all one word.

Okay. Thank you.

Why don't we move on to the next slide?

We're going to do a couple of practice questions. And just as a reminder to attendees, voting will be for Workgroup members only. Workgroup members, please make sure you are logged into your voting account and have navigated to the Core Set Review voting page. And you can remain on that page for the duration of this meeting and new questions will pop up as we make them available. But if you don't see a new question, just refresh your page and it should pop up. If you need any help, feel free to refer to the voting guide or send us a message through Q&A. Also, during voting on measures, if for any reason you're unable to submit your vote, please send it to us through Q&A. Your vote will only be visible to the Mathematica team who's monitoring that Q&A.

All right. So, now I am going to ask my colleagues to take us through the practice voting. And we'll do two different practice votes to make sure everyone can access the voting platform. I'll just ask for everyone's patience as we figure this out and help folks troubleshoot. Linette, did you have a question?

Well, I logged in and then all it's been doing is giving me my history from our last Core Set conversation, and I'm not managing to get to the new. So, I'm going to try again.

Okay. Try again. Let us know if it doesn't work. We did just reforward the voting information to Workgroup members. So, if you haven't gotten it, you might want to refresh your inbox. We have 11 of our Workgroup members on the line. It looks like eight folks have voted already. So, if you have not been able to submit a vote yet, let us know. You can unmute yourself and ask a question or raise your hand. Samantha, I see you have your hand raised. Is that from your question before or did you get the voting guide we reforwarded?

So, once it says, like, "Dismiss" or whatever because I voted on the [inaudible] thing. Then what happens? It doesn't seem to move through the next one.

Which question are you seeing? Are you seeing the pancakes one or the beach one?

The beach one.

Okay. So, that's still the active question. We haven't moved.

Oh, okay.

All right. Why don't we move to the next question? We've got 10 folks, so it looks like we might have just been missing you, Samantha. We're going to move to the next question. We'll just try it again. It looks like folks are not beach people. That's okay. So, the next practice question is whether you're ready for summer to end. So, if you're on the Poll Everywhere platform, please do vote just so we can make sure we're capturing everybody's votes. And Samantha, let us know if you're still having trouble. You can also send in your answer via Q&A.

So, with the last one, I got the thing saying, "We registered your responses," for the beach, but when I click this one, I don't get any message. Does that mean it's still going through your all's servers or something?

It may. It looks like we did get your response.

Okay. It just is not giving me the –.

Yeah. Yeah, it's weird that you didn't get the confirmation. Let us double-check that we got your vote recorded.

Same thing happened to me as well. Basel.

Okay. Great. Good to know.

Yeah, same here.

Me, too. I think it's a, like, new user kind of type of thing, and then once you click "Dismiss," it doesn't show them anymore, I think.

Okay. That's good to know. I can confirm that we did get – David, we did get your response. So, I think that must be it. We're still getting everybody. Samantha, I think you're the only that we haven't gotten yet. Are you still having trouble? Is there anything we can help try to troubleshoot?

Yeah, I'm trying to use the Q&A. It's just now allowing me to get into that.

Okay. That's fine. If you send your responses via Q&A, it will just go to our team.

Going to the host and the presenter, is that correct?

Team, who should the question be directed to? Is it all panelists?

All panelists.

Yep, all panelists. Thank you, Dayna. All right. Thanks everyone for sticking with us as we tested out the voting. Actually, it looks like we just got an 11th vote. So, okay, that was our team. Just making sure. Okay. Thanks everyone. I think we will move along. And just as a reminder to Workgroup members that you can keep that platform open on another screen or just in the background and the questions will – the new questions will pop up when we move into voting, or you can refresh your screen. So, moving along, now we will discuss the measures that were suggested for removal. So, if we can go to slide 34.

Okay. So, just as a reminder, three measures were suggested for removal. We will present each measure briefly with some information about the measure and then have a Workgroup discussion about that measure. After the Workgroup has discussed all three measures suggested for removal, we'll have an opportunity for public comment and then proceed to Workgroup voting on the three measures suggested for removal.

So, next slide, please.

The first measure suggested for removal is the Ambulatory Care: Emergency Department Visit, or AMB, Measure. This measure captures the rate of emergency department visits per 1,000 enrollee months among health home enrollees. The measure steward is NCQA and it is not NQF-endorsed. The measure uses the

administrative data collection method. And the slide here lists the denominator and numerator statements for this measure.

Next slide.

Thirty-one of the 35 SPAs that were expected to report this measure for FFY 2019 reported AMB. The measure is also on the current Child Core Set. Two of the Workgroup members suggested this measure for removal and cited concerns about the measure's actionability. For example, they noted that health home programs may not have control over all populations going to the emergency department. In addition, some health home programs may not have sufficient enrollment to produce reliable and meaningful results on this measure. Finally, a measure of overall emergency department use does not provide the ability to analyze the condition driving the ED use for purposes of quality improvement.

We also wanted to mention that the AMB measure was recently recommended for removal from the 2022 Child Core Set. NCQA has noted that it had planned to retire the AMB measure for its Medicaid line of business. However, NCQA recently indicated that the measure will not be retired until there is a replacement measure.

Next slide.

So, now I'd like to open it up for comments and questions from Workgroup members on the AMB measure. Please use the raise your hand function and you should be able to unmute your line if you wish to speak. And we will just call on folks in the order that hands are raised. So, comments or questions on the AMB measure? I see Dee. Dee Brown, you want to go ahead?

Yes. Thank you. I see a replacement measure on the additions list, which is the Follow-Up After Emergency Department Visit for Mental Illness, and that is something that I think the follow-up is actionable by the care managers and I agree with the other reasons for removal.

Thanks, Dee. Theresa.

Thank you. I would agree with removing it if we accept the other ED measure. I think removing it altogether and not showing this as a factor that case management will help individuals avoid emergency room visits is a disadvantage. So, I think I would be for removing it if we're able to add the other one. And I'm not quite sure – so, if we vote to remove this one and we vote not to add the other one, could you just clarify, where does that leave us next time? Does that mean that we can't reintroduce a measure until the next voting cycle?

Yeah, that's a good question and a good one to revisit. So, you are correct that we would first vote on removing this measure and then adding the other measure. So, the votes are intended to be separate from one another. They're not conditional. And yes,

there is not an opportunity to suggest a measure for replacement during this cycle. That would have to be for next year's review process. CMS ultimately does make the decision about removing and adding, and they'll take the conversation into their decision, but that is generally how the Workgroup process would go. Does that help, or Margo, is there anything you'd add?

I would just underscore the point you made, Tricia, just now about the fact that all of the comments that you're making are very important. So, I think you should vote on the measure on its individual merits. But all of the comments that you're making about the fact that you prefer not to have this removed unless there is a replacement will certainly be recognized in the deliberations of what CMS's ultimate decision is.

Thanks, Margo. The next hand that I saw up was Fran. Fran, go ahead.

Yeah, I have a couple questions. First, why isn't it endorsed, the NCQA? I don't know if that matters. And then the second question would be, I'm not sure the point that -- I just don't understand this; that the folks going to the ED is not an actionable -- something that care managers can do. I mean, I see one of the important things about a health home is working with the member to connect with them, the health home, before -- they should know the idea will be to know them well enough to work with the member to understand when they bill, when they reach out, when they should seek acute care. You know, they're supposed to have 24/7 contact, so why don't you call them, as well as education about when it appropriate to use the ED versus not. So I kind of see getting the right care at the right time at the right place a key function of health home, so I'm not sure how that information isn't actionable, so I'd like a little more talk in this section, I guess, about that.

Yeah. Dee, can I ask you to comment on Fran's question about actionability, and then while we're doing that, if there's anyone from NCQA on the line, we can go to you to comment about the endorsement question.

Sure. The thought process is this is a per-one-thousand measurement criteria, so you have to have at least a thousand members who went to the ED who were in a health home, and it doesn't describe any kind of -- whether it was avoidable or not avoidable, so it's a very difficult measure to show. While I don't disagree that they should not be effectuating people going to begin with, it's measuring a larger population group than most health homes have control over. The other actionable piece that I think is important, because health homes do remove and reduce the number of ER services, I think the best thing they can do is to ensure that a member, if they do go to an ED, for whatever reason, whether it was necessary or not, because sometimes it is necessary, that they get them to proper follow-up care afterwards, and that's the most important factor in being able to measure the effectiveness, or the care manager is able to get a member to either a behavioral health therapist on mental illness or to a primary care physician following an incident that was medical in nature. So, I think that was a thought process. And it's very difficult to measure per-one-thousand members that are all in a

health home, and no matter what the causation of the ED visit was, and so possibility to show quality improvement.

So it's basically not specific enough.

Right. That's what I'm thinking, yeah.

Okay. That makes sense. Thank you.

Yeah, this is Tricia. I would just clarify that the denominator is one thousand enrollee months, so it's not necessarily a thousand enrollees every month, but each enrollee's contribution based on their enrollment in the health home program. I think the next hand that was up was Pam Lester and then Kim Elliott and then Cindy. So, Pam. Pamela, are you on the line? Can you unmute, or Derek, do we need to unmute Pamela?

There we go. I couldn't get myself off mute. Thank you. So, this is a measure that we actually do use. We don't use it by itself, of course, but it does give us a good idea of ensuring that they're coordinating care to the appropriate space, just like Fran said. Much of what Fran said, I would echo. It helps us understand if they're involved in crisis plans, and, also, transitions of care, so those are some of the things that I think of with ED, which goes to Fran's point of getting them back to the primary care provider.

We also have analytics that looks at ED usage and we look at what diagnoses are presenting to the emergency department, and we're also identifying those high utilizers and have problems at their end. So that's where we do the work and identifying where the opportunities for improvement are in those measures. But that measure per-one-thousand really evens the playing field as far as risk of members, so I do like that. And I really do like this measure, just because of just the snapshot of how we did in the year with, really, ensuring that people had action plans as far as whatever their diagnosis is, whether it's a mental health or physical health, or if they're diabetic, you know, here is what your numbers look like if they're normal, if they're yellow, you need to go to the doctor, here's the red, when you need to go to the hospital to really help them control and own that diagnosis and really become good self-managers.

And I feel like this measure really helps us indicate whether that work is being done, and then the analytics that we have alongside this really help us maybe which ones are struggling with that, and then by looking at those higher ED utilizers, what are some things that are going through a chart review that maybe we can do some training on or provide technical assistance across the board to really help reduce those high ED utilizations. Maybe it could be a social determinant of health issue as well, but really using that nailing down to identify those opportunities that to have this measure as a snapshot on how the overall progress is going.

And I do agree with my chronic condition health home, it is a small population, so if you have variation in the results, and I find myself every year talking about I'm going to have

that variation because of my small population, but my other state plan amendment is quite large and, really, this is a really good measure for that.

That's really great. Before I go to Kim, I did want to ask Alyssa Hart from NCQA if you are on the line, if you're able to comment on Fran's earlier question about the NQF endorsement status of this measure. We may need to unmute Alyssa. Alyssa, go ahead if you can hear me. Why don't we move along to Kim Elliott? Is there anyone else from NCQA? Please use the hand-raise feature if you're on the line and can speak with us. Lauren Niles.

Can you hear me?

Hi, Lauren. Yeah, I can. Yes, go ahead.

Thank you. I think I submitted going through the Q&A too. But I couldn't find how to connect. So, this is Lauren from NCQA. I just wanted to respond to the NQF endorsement. We don't see NQF endorsement for all of our measures. We've never sought NQF endorsement for this particular measure. So, I think the reasons for that is, it's not risk adjusted and utilization measures that are unadjusted really provide, I think, marginal information on quality and accountability, so those are key endorsement criteria for NQF, so that was one of the reasons we want wanted to steer away from that. But, certainly, it's a useful measure, although it is being considered for retirement from HEDIS. But I totally agree with the discussion about maybe replacing it, and, of course, being a key area for quality and for accountability. So, happy to answer any other questions or direct you to the right folks at NCQA that might be able to help further.

Thank you, Lauren. Okay, Kim Elliott, go ahead and make your comment.

Thank you. I agree that this is a really good measure for both of the different types of health homes. But I think when I look at the measures of the core measure set, it is heavily behavior health, which is good, because that's where the majority of the population is. However, the follow-up is really critical in avoiding this ED, so establishing those relationships is important in that health home and encouraging them not to need to go to an emergency room.

And when I'm looking at the measure that we're talking about for addition, it's really not measuring the same thing at all. It really is follow-up, strictly from the behavioral health visit or mental health visit. So it really is a totally different population, potentially, and totally different measure, so I don't want us to really think that it is a replacement measure for this one.

Thank you, Kim. Next, we have Cindy, Cindy Brach, go ahead.

Thank you. I have a sort of broader question raised by some remarks that Fran made, which was that the measure wasn't the purview of the care manager. And I may be confused, but my understanding of the measurement set was to establish accountability measures for the health home program overall that was consistent with the goals of the program, so what is seen as trying to achieve, what are the states buying into in their program, not evaluating particular program design, so that if there is an overall goal for the program and the state's intervention is only a care manager and the care manager can't meet that goal, then that says, to me, that the program needs to shift in some way to be able to address that goal. Am I totally missing the mark? Are these measures supposed to be evaluating care management per se?

Thank you for your comment, Cindy. There are a lot of other Workgroup members who want to make a comment, so I'm sure others will speak to that. Karolina, you are next.

Before you move on, I don't know if maybe Margo or someone from Mathematica or CMS can just address the purpose of this measurement set.

This is Margo. I'll jump in real quickly, Cindy. I think the purpose, as you may have noted, is to measure the overall quality of care in the Health Home program in terms of care delivered to Medicaid beneficiaries. The goal is to be able to use those measures to drive improvement in quality. So I think what you're hearing from the Workgroup folks this morning, and now in their comments about this specific measure, is the challenges that some say, not all, but some, face in using that measure as an indicator of overall performance and, also, this their ability to drive improvement in reducing inappropriate ED use. But I think what you're also hearing is that there's the diversity of perspectives in how this measure could be used within the health home program. So I think with that, I think we should go on to Karolina. And I'm sure other people will have other thoughts on how this measure can be used or how it may be a challenge.

Hi. This is Karolina. So I agree that one of the really big shortcomings of this measure is its inability to analyze the conditions that are actually driving ED use. But we also in Minnesota kind of made a commitment that will try to find high utilizers of ED visits based on this measure. They think there's some opportunity here. I personally don't think about this measure as a measure that can be used as a tool for quality improvement. One of the reasons is because it is the denominator is number one, which allows, actually, standardization and comparison across different populations, which is nice. But I think there are different things for quality improvement that can be used to minimize that inappropriate ED use, but this measure is a good measure for me personally to just monitor utilization, especially since we have observed that our behavioral health home patients are higher utilizers of emergency department visits compared to Medicaid overall. So, I like monitoring this measure, and I think even if it was retired, we will still monitor our behavioral health home.

That being said, I have a question for the measure steward. I wanted to know why this measure was considered for retirement. What were the reasons for NCQA to consider

this measure for retirement? And I wasn't sure, is it still considered for retirement or was the decision made that it is not considered for retirement anymore?

So, I don't [inaudible]. This is Lauren Niles again.

This is Margo, I can speak to this, because I actually was in touch with NCQA just yesterday about this very topic. So, this measure is still being considered for retirement for the Medicaid line of business. It has been retired for other lines of business. But it is in the Core Sets, both Child Core Set and the Health Home Core Set. The consideration, however, is, we should not retire it, at least at this point, based on information that's currently being considered by NCQA until there is a replacement measure.

Some of you may know, if you're into the HEDIS measure set, there's EDU measure, and I believe it's called AHU, that would be considered. They do not have Medicaid risk adjustors at this point, so they would not be appropriate, at this point, for the Core Set as they're currently specified in HEDIS. So, that is situation, Karolina.

And I think what I would suggest, at this point, is that this group is to consider the utility of the measure as it is currently specified to consider that it is still in the Core Set. There is no intent of retiring it for 2022, and probably not for 2023. There is a big line for developing a new measure or risk adjustment, and so that is the information that has been shared, with us and also shared with CMS. So, I think that's what I would suggest to the Workgroup, is consider the measure as you are using it now and as you will be using it over the next couple years.

Margo, I actually wanted to speak a little bit about this alignment with the Child Core Set, because this measure technical specifications for the health home AMB measure are a little bit different than for the Child Core Set measure, in that this one does not exclude behavioral health and chemical dependency services. But the fact that the technical specifications are different, what it means, at least for my team, is that we should be able to compare where we calculate, like, Medicaid rates, using the technical specifications in a Health Home Manual just to be able to compare because of that exclusion criteria. So, I was wondering if it would make sense to align these measures, actually, so they are more comparable as far as Core Set.

That's a great point, and your timing is very good, because we are just starting on the path to updating the Core Set specifications, so we will definitely consider that. What I would say, for purposes of voting for this measure, for the Health Home Core Set, is that you measure the measure as specified for the Health Home Core Set. We certainly will consider your point about alignment between the Child Core Set and the Health Home Core Set. I believe some of it has to do with slightly different populations in the two groups. But we'll definitely make note of that and look into that as we begin the journey of the updates for 2022. So, thank you, Karolina. We really appreciate all your wealth of knowledge about the measures.

Lauren Niles from NCQA, I know you were also going to jump in. Is there anything you would add?

Can you hear me? Yes. No, thank you, Margo, so much. I think that's all we would say as well.

Great. Thank you. Next, it looks like David Basel, you were next in line.

Thank you. As I was listening to the conversation, I was hearing that several health homes are finding value in using this internally for performance improvement, and I was kind of leaning towards that direction until the comments about this not being risk adjusted, and the comments about this being used for performance monitoring. And without it being risk adjustment, that's kind of a showstopper on this metric for me, because if you're trying to look, comparing programs to each other, or even comparing groups within a program, without that risk adjustment, you're really comparing how sick that population is, as much as you are the actual ED visits. And so that was kind of the key point to me, that's swaying my vote right now as I listen to this.

Thanks, David. It seems like the last comment we have is from Dee Brown, and then we'll move on to the next measure. Dee, go ahead.

Hi. Thank you. What I wanted to just bring to everybody's attention, that's existing in the Health Home Core Set today is Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, and according to the prior comments, you know, the addition of Follow-Up After Emergency Department Visits for Mental Illness is an addition, and then removal of this one seems to be better fit for measuring health home care management effectiveness.

Thanks, Dee. Real quick, before we move on, I see, Kim and Cindy, your hands are still up. Did you have additional questions or is that hand up from before. Okay, the hands went down, so I'm assuming it was from before. Thank you everyone on the Workgroup for that super robust discussion. Why don't we move on to the next measure?

Next slide.

So, the second measure suggested for removal is the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, or IET measure. This measure captures the percent of health home enrollee age 13 and older, with a new episode of alcohol or other drug abuse or dependence who receives initiation of treatment within 14 days of diagnosis, and engagement and ongoing treatment within 34 days of the initiation visit. The measure steward is NCQA, and it is NQF endorsed, and the measure uses the administrative or electronic health record data collection method.

Next slide.

This slide contains information about the denominator and numerator for the IET measure. SPAs report measures stratified by four different diagnosis cohorts. Those are alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence, and a total alcohol or other drug abuse or dependence.

Next slide.

Twenty-seven of the 35 SPAs that were expected to report this measure for FY 2019 reported IET. The measure is also on the Adult Core Set, and the Workgroup member who suggested the measure for removal indicated that it may be difficult for health home programs to track this measure, and that other measures could potentially replace the IET measure.

Next slide.

So, now we'd like to open it for questions or comments from Workgroup members specific to the IET measure. Again, please raise your hand and we'll call on you in the order the hands are raised, and you should be able to unmute yourself. Comments or questions on IET? David.

So, this is the one that I feel probably most strongly about removing, at least for a rural state like South Dakota, breaking this into those separate domains, the Ns get so small that it's really just a meaningless measure for us, and the difficulty in obtaining this information, and the lack of information gained out of that process, we were pretty excited to see this one being proposed for removal.

Thanks, David. Are there question or comments on this measure? Linette, Go ahead.

I would just echo what David is saying, that the way the measure is structured, with all of the different sub-categories, this is going to be a harder measure to be actionable for, just because of some of the small accounts that come into play when you're looking at the subpopulation that is in the health homes. So it's not diminishing the importance of coordination for services, which is, of course, one of the key goals of the health homes program. But this measure, in and of itself, probably just because of the way it's structured, it's hard for those small numbers. And I'm in California, but, still, the number of people that are enrolled, and in this particular area of services, we can still run up against that issue. Thanks.

Thanks, Linette. Pamela, go ahead.

I would just like to echo what the other two have said. Really, it's been a struggle to use as an actionable measure and agree with the suggested measures as replacement measures.

Thanks, Pamela. Other comments or questions? Linette, I still your hand is still up. Is there anything else you wanted to add? Okay.

Sorry. Trying to program the take hand down.

That's okay. That's okay. Are there comments on this one? All right.

Why don't we move on to the next slide then?

So, the third measure that was suggested for removal is the Screening for Depression and Follow-Up measure or CDF. This measure captures the percentage of health home enrollees age 12 and older screened for depression using an age-appropriate standardized depression screening tool, and if the screen is positive, a follow up plan is documented. The measure steward is CMS and it's no longer NQF endorsed. The measure uses administrative or electronic health record data collection method and the slide also contains information about the denominator and numerator.

Next slide.

Twelve of the 35 SPAs are expected to report the measure for FFY 2019 reported CDF, and the measure is also on the Child and Adult Core Sets. The Workgroup number who suggested measure for removal indicated challenges of providers coding the information needed to calculate the measure in administrative claims.

Next slide.

So now we'd like to open it up for questions, comments, discussion from the Workgroup on the CDF measure. Raise your hand, and you should be able to unmute yourself. Fran, go ahead.

I think this is a really important measure from a clinical perspective because it is actionable, right? Depression is, I don't want to say easy to treat, but it is a very treatable condition. It's very prevalent, and it has, it is a significant contributor to worsening of other chronic conditions and outcomes, you know, such as suicide and drug use and people with cardiovascular disease with depression do worse, and so I think this is a fairly -- I like this measure, for what it's worth. And then I think we can, from the coding perspective, we can teach providers how to code it better, I would hope.

Thank you. David, it looks like you're next. Go ahead.

I was wondering why NQF is no longer endorsing it if we knew that. If I think back to CMS, if I remember right, they did some updating of this metric and changed the numerator and denominator criteria a fair amount. Is that what we're looking at? It's not so much that we don't agree this is an important measure, but that the measure steward has changed the measure significantly and that we need to adopt a newer version or something? That was my question.

Thanks for that question, David. Is there anyone from CMS on the line familiar with this measure who could speak to that? If so, please do so. Raise your hand function and we will unmute you or let us know in the Q&A and we'll unmute you. No. Okay. Margo, I think you might have something to add here. Go ahead.

I do. We have asked about this in the past. I think it's very similar to what you heard from NCQA about the AMB measure, is that not all measure stewards go for either endorsement the first time or renewal of endorsement. It's a very lengthy process, and so, my understanding about this measure is that they did not seek for renewal of the endorsement, so it lost its endorsement. And so I'll also just remind everyone that, to be in the Core Set, any of the Core Sets, NQF endorsement is not required. It's something that we mention and note, but it is not required to be in the Core Set.

Thanks, Margo.

The measure went through a lot of changes recently.

Thanks. Jim Bush, I see you have your hand up. Go ahead.

Yeah, no one is disputing the clinical importance of follow up of depression screening for depression. But I'm wondering if this -- you know, when I was reading your background material, it looks like it may just be the way that the data is collected, it becomes cumbersome and challenging. It looks like 11 SPAs did not--, they were just saying they were having inability to calculate. And I'm just wondering if this is maybe an older measure and maybe there might be better ones coming along, because I agree with the earlier speaker that, I mean, clinically, obviously, this is important, but I'm not sure this is the best designed measure, and I thought that was one of the criteria we were supposed to be looking at, is that element as well.

Thanks for that comment, Jim. Linette, did you have something to add or to respond to that?

Yeah, maybe just to echo that aspect of the challenge with data collection. So, again, absolutely agree with the importance from a clinical perspective, in terms of screening for depression. But one of the challenges for this measure is the documentation, so there are some codes and claims that could come through, but they're not necessarily used routinely, so that may mean it triggers to a chart review to assess whether there's a true follow-up plan. And any time you have a chart review measure, it just is a higher workload and higher cost to collect the data, and so it just makes it harder to do, and so I think we see that in terms of the number of SPAs that are responding and reporting it. It just reflects the challenge of data collection, not importance of the measure.

Thanks, Linette. Karolina, I see you have your hand raised. Go ahead.

I just wanted to second that comment. We have not been able in Minnesota to calculate this measure, either for the Adult Core Set or for this ever, and it doesn't look that we will be able to. So, even though it's very important, we just are not able to calculate it.

Thanks, Karolina. Theresa, go ahead.

Thank you. I would just like to go on record that the three that are being asked to be deleted are ED visits, use of opioids, and screening for depression, all which are large political issues. If you take a step back from the health home, and as we try to tell the story of health home, can health homes reduce ED visits, can health homes improve opioid use, and will health homes improve accessing mental health services? I think if our discussions that we've had is that the measures that are available to us don't measure what we need to tell the health home story, then I would like to encourage CMS to think about, in the future, maybe the measures available aren't telling the story for health homes and aren't giving us the data that we need within a state to justify the utilization.

So, I'm not for or against. I'm not saying that we shouldn't remove these or we should keep these, but I just think that removing them does give the impression that they're not important, when, in fact, it's the measurement that's not supportive of what states are trying to tell, of the story states are trying to tell.

Thanks, Theresa. Libby Nichols, you were next. Go ahead.

Hi. I just kind of wanted to echo some earlier comments about reporting difficulties and how it's tough to balance the importance of measures, especially when we're trying to really describe the Health Home Program and describe potential successes. But I think one of the other things that has come up earlier in previous discussions with the Workgroup is sort of reporting burden and, also, just the notion of the more measures there are, the harder it is no know which ones to focus on. And so, to me, that really lends itself towards being really thoughtful about if we're having trouble reporting or if there's a lot of burden going into collecting the measure, and what we're getting out of it is not necessarily feasible for a lot of folks, and there are, potentially, other measures, or there one there might not be an exact one-to-one replacement, but just sort of keeping in mind the fact that there's sort of an overall number of measures, and if we're having trouble with one being -- like, do we really want to spend efforts collecting for a measure where other measures might give us more information because we can collect them and turn that data around and make it into useful information faster. I'm not sure if I'm totally explaining that the right way. But I'm mainly echoing previous comments, so.

Thank you. Dee Brown, you were next. Go ahead.

Thank you. I wanted to speak to both Libby and Linette talking about the data collection challenge. It is a challenge to collect this because it's not a billable encounter, and so whoever is doing it does result in, typically, chart audits and not necessarily a health

home chart audit and health home EHR, but the primary care physician, and so I think it is a difficult measure.

I also am sympathetic to the fact of how are we telling our story about health homes. And I just want to bring to everyone's attention that Follow-Up After Hospitalization for Mental Illness, Use of Pharmacotherapy for Opioid Use Disorder, Follow-Up After Emergency Department for Alcohol and Other Drug Abuse or Dependence, all of these are not being asked to be removed, and we're adding some other measures that are up for vote. I just think that we are telling the story. I think it's that being able to tell that story and tell it without a burden on the health homes and allow the health homes to focus on the care management things that they are doing for the member and less on trying to capture a measure that's very hard for them to capture.

Thanks, Dee. Jim, I think you're next. Go ahead.

Yeah, along the lines of several of the last speakers, I don't view the removal of these three measures is not saying the emergency use, opioids, and depression isn't important. But it's like the earlier days when we were trying to use electronic clinical quality measures. And, what we found is that every clinic was calculating them in a different manner, and, really, you're not telling the story accurately about what the health homes are trying to do if your data isn't consistent and really reflects the reality of what's happening clinically. And so, I think what these three measures are showing is that they're challenging and they're probably not as accurate as we would like to think they are as people are going along. Again, clinically, these are all very important areas, but I think as we are learning more and more and more about how do you design quality measures, we shouldn't be afraid to leave the old ones and look for better more accurate quality measures, and so I just want to make sure we're not saying these aren't important topics but just probably defective -- not defective, but not as accurate measures as we would hope to be able to have today, so that's my point.

Thanks, Jim. I just want to check, Libby, I see your hand is still up. Did you still have something else to add, or is that from before?

Oh, no, just forgot to lower it. Thanks.

No problem. And then, Pamela, I see your hand up. Go ahead.

I have a passion for this measure. I agree with what everyone saying, that it's really important. One of the things I'm just fighting with myself with is that they’re trying to get providers to code for what was done during the visit, because that really captures the true risk to the member and give us lots of information in that claim. So, I'm struggling with, you know, is it that we need to maybe work on getting providers to document on the claim what was done, and then ultimately would make this measure more accurate, or is it better at this time to pick a measure that would help capture and help show how well we're doing or the work that needs to be done around depression and follow up.

Thanks, Kim. All right.

Now I would like to open it up for public comment, so let's go to the next slide.

Yeah, thank you. If there's anyone on the line from the public who would like to make a comment, please use the raise your hand feature in WebEx and we will unmute you to speak. Angela, go ahead.

Good afternoon. Just a comment regarding the information and the difficulty. At the provider level, they are documenting depression screening ER visit follow ups in their record. So, I know this might be something for the future, but improving the ability for data to be submitted from the electronic health record and have that be accepted versus relying only on the administrative claims, because you're going to run into this with tobacco, if you ever add anything for tobacco, if you add things for A1c level, obesity, some of those pieces. So, working on not just using administrative claims, because NCQA is working on data validation to an audit process, so many of the vendors are entering that protocol and process, so that's something to consider, because it is being documented by the providers.

Thanks, Angela. If you wouldn't mind, just for the record, would you mind introducing yourself and telling us your organization affiliation.

Okay. Sorry. I'm Angela Herman-Nestor. I work for the Missouri Primary Care Association, and so I support organizations that are participating in the primary care health home here in Missouri.

Great. Thank you so much for your comment. Next, I see Jeannie Wigglesworth. We can unmute you if you would introduce yourself and your organizational affiliation and share your comment, please.

Sure. Great. Thank you. My name is Jeannie Wigglesworth, and I work under Beacon Health Options an ASO in Connecticut and oversee the behavioral health home in Connecticut, and our main focus is the SMI population. And for the CDF measure, what we are finding -- and it's just one example, this measure is just one example of some difficulties we have -- is that our providers are behavioral health providers, so they are doing depression screens all the time, and it's not necessarily on an outpatient visit, so we often will lose that, and our rates are grossly underrepresented of the actual depression screenings that we do.

The IET, we find, is an important measure also, but a lot of the behavioral health providers also have primary diagnoses of the behavioral health, and if it requires a primary diagnosis of SUD, sometimes those people are missed in the intervention. So, you know, on a smaller scale, those are some of the data issues we have that we find, that these measures don't act at least represent the interventions that we are offering.

Thank you, Jeannie. Other public comments? And just as a reminder, this is public comment for all three measures that were suggested for removal. Okay. Well, thank you to the workgroup, and to the public for the discussion today.

Now we are going to move into voting on these measures, so let's move to the next slide.

And I will ask my colleague, Erin, to pull up the voting platform.

All right. So, for our first vote, the question is, 'Should the Ambulatory Care: Emergency Department Visit measure be removed from the Health Home Core Set', and the options are, 'yes, I recommend removing in measure from the 2022 Health Home Core Set' or 'no, I do not recommend removing this measure from the 2022 Health Home Core Set?' And voting is now open.

All right, we were expecting 11 votes, and we have received all 11 votes, including we've got yours, Samantha, in the Q&A. The voting is now closed. And can we show the responses. For the results, 45 percent of workers members voted, 'yes', that does not meet the threshold for recommendation. The Ambulatory Care: Emergency Department Visits measure is not recommended by the workers for removal from the 2022 Health Home Core Set.

Let's move on to the next vote.

For our second vote, the question is, 'Should the Initiation and Engagement of Alcohol and Other Drug or Dependence Treatment measure be removed from the Health Home Core Set?' The options are 'yes, I recommend removing this measure from the 2022 Health Home Core Set', or 'no, I do not recommend removing this measure from the 2022 Health Home Core Set.' Voting is now open.

We were expecting 11 votes, and we have received 11 votes, so voting is now closed. Can we share the results? For the results, 82 percent of Workgroup members voted, 'yes', that does meet the threshold for recommendation, so Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure is recommended by the Workgroup for the 2022 Health Home Core Set.

Next question.

All right, so our third vote is, 'Should the Screening for Depression and Follow-up Plan measure be removed from the Health Home Core Set?' The options are, 'yes, I recommend removing this measure from the 2022 Health Home Core Set' or, 'no, I do not recommend removing this measure from the 2022 Health Home Core Set'. And voting is now open.

You guys are pros at this voting. We were expecting 11 votes, and we've got all votes in, so voting is now closed, and we'll show the responses. For the results, 73 percent of

Workgroup members voted, 'yes', that does meet the threshold for recommendation. The Screening for Depression and Follow-up Plan measure is recommended by the Workgroup for removal from the 2022 Health Home Core Set.

All right, and now let's go back to our slides.

If we can skip ahead to slide 50, the end of voting brings us to our second break of the day. I want to thank workgroup members for your engagement and questions, and your mastery of the voting platform. We will take our second break now. I would like to ask everyone to please be back at 2:35, so that's just shy of 20 minutes, so let's plan to be back at 2:35, and we'll discuss our first batch of measures for addition, so enjoy the break everyone.

Everyone, it is 2:35, so we will go ahead and get started. Welcome back from the break. This afternoon, in our remaining time together, we are going to discuss the first batch of measures that were suggested for addition, so I would like to hand it over to my colleague, Jeral Self, to present these measures. Jeral, go ahead.

Thanks, Tricia. Next slide.

The first measure suggested for addition is Follow-Up After Emergency Department Visit for Mental Illness. This measure measures the percentage of emergency department visits for beneficiaries age six and older with a principal diagnosis of mental illness or intentional self-harm and who has had a follow-up visit for mental illness. Two rates are reported for this measure, a 7-day rate and a 30-day rate. The measure steward is NCQA and the measure is NQF endorsed. It uses the administrative data collection method, and the measure is currently in the Adult Core Set and has been recommended for addition to the 2022 Child Core Set.

Next slide.

This slide contains information about the denominator and numerator for this measure. Note that the denominator is based on ED visits not beneficiaries, and the follow-up visit could be with any practitioner.

The second measure suggested for addition that we'll discuss today is Asthma Medication Ratio. This measures the percentage of beneficiaries ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. NCQA is the measure steward, and the measure is NQF endorsed. This measure uses the administrative data collection method and is currently in both the Child and Adult Core Sets.

Next slide, please.

This slide contains information about the denominator and numerator for this measure, including the criteria as an individual must meet to be included in the denominator.

Next slide.

Now I'd like to pass it back to Tricia to facilitate the Workgroup discussion about these two measures suggested for addition.

Thanks, Jeral. So, we will take our session in two parts. We'll first start with the discussion of the Follow-Up After Emergency Department Visit for Mental illness measure. So let's start with that measure. Any comments or questions from Workgroup members? And just as a reminder, please use your raise your hand feature, we'll call on you and you should be able to unmute yourself. Questions, comments from the Workgroup on the measure. Dee Brown, go ahead.

I will say I like this measure. I like the fact that it's a 7- and 30-day, because sometimes you can't get a member to an appointment within that 7-day timeframe, but it also shows whether you were able to do it within 30 days, and it also allows for any practitioner to see the follow up. It's not a requirement like the normal HEDIS measure for follow up, this is after mental health hospitalization, which is also one of our measures. So, it does, you know, ensure that even a child is getting to a pediatrician, and then, subsequently, that pediatrician could refer them to behavioral health specialists. But one thing we know, with the advent with integrated care, many, many primary care practices are performing mental health follow-up services, and so for that reason, I like this measure. And I know we didn't agree to throw out the ER per thousand, but in thinking through that, this was an additive measure, and we also have the follow up emergency department visits for alcohol and other drug abuse, and we're measuring the use of pharmacotherapy for opioid use disorder, so I think this kind of rounds it out for the type of members that we have in our practices, and it's very actionable for the care manager.

Thanks, Dee. Jeannie Wigglesworth, I know you still have your hand up. If you wouldn't mind just putting your hand down until we get to public comment, if you have another comment, that would be great. Fran Jensen, go ahead.

I just have a question. Are the numbers enough for this to be meaningful? Basically, is there a big enough N for a health home? I guess that's my concern for mental illness.

Yeah, that is a good question. I will say that one of the comments from the Workgroup member who suggested this measure for addition was that this measure, theoretically, should have a larger denominator than the FUH measure, and the FUH measure is Follow-Up After Hospitalization for Mental Illness, so this measure under consideration, the Follow-Up After Emergency Department Visit measure should have a higher denominator, and the FUH measure that's currently on the Core Set is reported by most SPAs, health home programs. So, presumably, the sample size would not be a challenge, but I would invite other Workgroup members to comment on that as well. Karolina, go ahead.

I just wanted to say that I actually did track that in our population, and I just want to confirm that we did see that FUH would have a little bit larger denominator, would have a larger denominator than FUA.

Great. Thanks, Karolina. David, go ahead.

I think from my standpoint, I would rather have seen follow-up for any condition and not just for mental illness as a principal diagnosis, because most of the time, in my experience, they're showing up to the ED with migraines or some other issue, certainly with their intentional self-harm, that's there. But that number has got to be relatively small, at least in our population. And most of our patients' mental health are showing up with a different principal diagnosis. I would have rather seen it be followed up after all emergency department visits, rather than just one listed, mental health, because mental health plays a role in at least half of them.

Thanks, David.

So, based on their chief complaint or their -- right, because you can't necessarily diagnose. But it's based on their discharge diagnosis from the ED. But I totally get your point that most of the time, it may be different presenting and/or discharge diagnosis from the ED. Is that what you're getting at? You don't go in there and say, "I'm having a mental illness." It may manifest itself as something else.

Certainly, that's what I've seen.

Okay. Okay. Just asking for clarification, that's all. Thank you.

Thank you. Kim Elliott, you were next.

I do like this measure, and I think it touches on several different elements from our home health, such as the care coordination element, heads down the road a little bit closer to outcomes. It is that relationship building in the health homes, and it's an easy measure to actually capture information and data, so it's very doable measure. I like it.

Thanks, Kim. Dee Brown, you were next.

I just have a question that David brought up. I don't know that there is a measure for all-cause emergency room follow up that's available, and that's a question to the larger quality teams. Maybe, you know, when we get to public comment, they can comment on that, but there wasn't a measure added or recommended for addition that has that value in it. I'm not aware of one that captures that value.

This is Margo. I would just like to suggest that Workgroup members, as you hear things like that, pin that for the conversation tomorrow when we talk about gaps and future

directions. I think we heard some earlier today as well. So, I encourage you to be making a mental or a handwritten note about that so we can talk more tomorrow.

Thank you. Jim Bush, you have your hand up.

[inaudible] denominator and numerator, I was wondering about the logistical feasibility of the numerator, because they're talking about with any diagnosis of mental health disorders within 30 days of the ED visit, and I don't know if that ties in with the fact that some people will present with a somatic complaint, especially kids can have somatic issues, and then later on the diagnosis comes up. Am I understanding that right, and is this really going to be, again, a challenge for our health homes to aggregate all this, because it's just not off of claims data, or it's not going to be easy claims data? So I just wanted some clarity on that.

Thanks for that question, Jim, are there any members of the Workgroup who want to comment on that. And Lauren from NCQA, you also have your hand raised, so, Derek, can we unmute Lauren.

Hi. Can you hear me all right?

We can, yes.

Great. I just wanted to provide just a little, if I may, clarification on that last question. So, the measure is looking for folks that have an ED visit for a diagnosis of a mental health condition, and the value set there is quite broad, including SMI, but also a lot of other more mild conditions. And then it's looking for follow-up, again, those two time periods, and then follow up has to also include the diagnosis. It doesn't have to match the one on the ED discharge, but there has to be another mental health diagnosis. The reason being, it's really about making sure that that follow up is targeted to the mental illness component of the ED visit, and that's the intention there. I don't know if that helps clarify, but happy to answer any other questions.

Thanks, Lauren. Jim, does that help answer your question?

Yes, it does. Thank you.

Great. Thanks, Lauren. Other comments or questions about the Follow-Up After Emergency Department Visit for Mental Illness measure. Dee Brown, go ahead.

My last comment on this is that, just to note, that it is already included in the Adult Core Set, and it's been suggested for addition to the Child Core Set, which aligns the Health Home Core Set with those two adult and child measures, which was one of the criteria for us to think about.

Thank you, Dee. Any other Workgroup thoughts on this measure before we move on to the Asthma Medication Ratio measure? Okay. Well, why don't we move on and turn to

the Asthma Medication Ratio measure, which was also suggested for addition, and we'll take Workgroup comments or discussions on that measure, and after this discussion ends, we'll go to public comment for both of these measures. So, any Workgroup members, thoughts on the Asthma Medication Ratio measure? Dee, go ahead.

I feel like I'm commenting too often, but I do have thoughts about this. I think there's a lot of challenge in measurement for a health home program to capture this data. And, also, there's a two-year time period for the measurement criteria, and members don't necessarily be in a health home during that entire two-year time period, so how are we saying that it's impactful for the health home if there's a two-year measurement period, because somebody may be in a health home for six months, maybe a year, but they're not necessarily in there for the full two years.

Thanks, Dee, for your comment. And there's no such thing as commenting too much, so we appreciate it. Kim Elliott, go ahead.

After hearing what Fran said, I happen to agree with her, because the health homes don't have that regularly available pharmacy data. They would have prescribing, but not necessarily receipt of the actual medications, and that's one of the requirements for this particular measure. It's not just that it was prescribed, but that they received it.

Thanks, Kim. Other comments? Fran, go ahead.

Dee, I'm just like you, I comment on everything. When I was reading through this measure, I was incredibly confused. It's just very, to me -- I get it that you need to need on a control medication, and not just a rescue medication. And there is opportunity to do a lot of education, for sure. But I would think it would be days, like I said, it's very complicated and getting the pharmacy claims is almost impossible, and the timeline would be significant, I would also think. But, mostly, it's just really confusing.

Thank you, Fran. Other Workgroup comments? David, go ahead.

I agree, the wording of this metric is very convoluted, and I find it strange that when in the title, they're talking about having persistent asthma, but nowhere do they use a diagnosis of persistent asthma as the denominator. They use all these surrogate pieces rather than the actual persistent asthma diagnosis. I suppose they're trying to look at underdiagnosis, but if you're looking for asthma, look for asthma.

Thanks, David. Fran, did you have something else you wanted to add or is your hand up from before?

Oh, sorry. I'll lower it. I keep forgetting. I apologize.

No problem. Karolina, I see your hands up. Go ahead.

Yes, I agree that this measure is confusing. I did a little bit more research on it, actually, some years ago, and was considering to recommend it, but decided against it, because I'm not sure how prevalent actually asthma is among the behavioral health home that we have. But I think just want to say I think from what I understand about this measure is that it can be used to identify people who can benefit from extra attention and extra asthma care, and basically there's that ratio of below 0.5 would signal that someone has poor asthma control, and 1 would mean that the control is good. I think it could be a very actionable measure if the data was available quickly for providers to identify folks who could benefit from extra care.

Thanks, Karolina. Linette.

I guess one of the questions I would have is -- sorry. So, this is a measure we use in the Core Set in terms of the adult, child measures. But for the population that's in the health homes, do we know if there is enough prevalence of asthma to make this measure a worthwhile measure for this population? And the reason I ask is, I mean, asthma is a relatively prevalent condition, but this particular -- with the health homes, we're trying to address particular populations, and I don't know how much of an overlap there is for the populations in the health homes with asthma in particular.

Yeah, that's a good question.

I don't know if they have that information.

I'm not sure that we have health home-specific diagnostic information. The measure information sheet did include prevalence of asthma in the Medicaid population as a whole, which was about seven percent in children and eight percent in adults. But I'll let other members from the Workgroup weigh in if they have any thoughts. Pamela. Sorry, go ahead. Linette, go ahead.

Just to piggyback on that then, if it's seven to eight percent in the population in general, unless we are selecting for a population that has asthma, when we go from the full Medicaid population down to a very specific subpopulation, then if we were to just apply that if we have a hundred people in health homes, then there would only be seven people that have asthma, or a thousand people in health homes, there would be 70 people with asthma. It's not about whether I support the measure or not. I mean, because we have used the measure in a variety of ways, and certainly control of asthma is much better than dealing with acute outbreaks. But, given the population size of this particular group, I'm not sure that this is the best measure in terms of being where folks really need to focus.

Thanks, Linette. Pamela, you have your hand up. Go ahead.

Yeah, this measure, we, in our chronic condition, we do have asthma as a qualifying condition. We do see a prevalence of asthma. I think one of my conflicting thoughts is that the reason we want to track asthma and make sure they're appropriate medications

is so we don't have high ED utilization, and I think that we can capture that in other measures. So, I'm kind of struggling with this measure. Like I said, I think it's a great measure. We do have prevalence. It's a population that we have the criteria to enroll but think that we could probably do actionable work through ED visits.

Thanks, Pamela. Other comments from Workgroup members? All right.

Well, seeing none, I'd like to move to the next slide and open it up for public comment.

So, if anyone from the public would like to comment on either the Follow-Up After Emergency Department Visit for Mental Illness measure or the Asthma Medication Ratio measure, please raise your hand in the WebEx platform and we will call on you in turn. Angela Herman-Nestor, if you could just introduce yourself again and make your comment.

This is Angela Herman-Nestor with the Missouri Primary Care Association, so we partner with the Missouri Medicaid for the primary care health home, which is predominantly chronic diseases. So, the mental-health only diagnosis with follow-up after ED on the primary care side would mean that for the Core Set measure, there really wouldn't be -- there would be a very low number that would go into that on the primary care side, so we have about 35,000 involved on the primary care side in Missouri. We do have a behavioral health home as well, and they have about as many enrolled, so there would be some. And then also with asthma, we do have, on the primary care side, pediatric asthma is a standalone condition, so it counts as a chronic condition and at risk for a second one. And we also have quite a few pediatric-only practices, and asthma is the most prevalent reason for their enrollment in the health home but would agree that access to that medication-filled information would be a challenge for the primary care providers. But asthma is very prevalent if the health home has more pediatric patients.

Thanks, Angela. Jeannie Wigglesworth, I know you're having trouble lowering your hand, but I want to just confirm whether you had a comment to make on these measures? You might be double muted.

Hi. No, I don't have a question. It's just my hand. Sorry about that.

That's all right. Lauren Niles, I see your hand is also still raised. Did you have a comment on either of these measures? No?

Sorry. Apologies.

That's all right. That's all right. I just wanted to make sure I'm not missing anyone. Anyone else with a public comment on either of these two measures suggested for addition, Follow-Up After Emergency Department Visit for Mental Illness or Asthma Medication Ratio? All right. Well, seeing no more public comment, now we will turn to voting on the two measures that were suggested for addition.

Erin, I'll ask you to pull up the voting platform. And Workgroup members, please be sure you're logged in. Okay. So, the first measure that we will vote on is 'Should the Follow-Up After Emergency Department Visit for Mental Illness measure be added to the Health Home Core Set?' The options are 'yes, I recommend adding this measure to the 2022 Health Home Core Set', or 'no, I do not recommend adding this measure to the 202 Health Home Core Set'. And voting is now open.

We were expecting 11 votes, and it looks like we have received all 11, so voting is now closed, and we'll show the results for the results. 82 percent of Workgroup members voted 'yes'. That meets the threshold for recommendation. The Follow-Up After Emergency Department Visit for Mental Illness is recommended by the Workgroup for addition to the 2022 Health Home Core Set.

Next question.

So our next vote is, 'Should the Asthma Medication Ratio measure be added to the Health Home Core Set'. The options are 'yes, I recommend adding this measure to the 2022 Health Home Core Set', or 'no, I do not recommend adding this measure to the 2022 Health Home Core Set'. Voting is now open.

Again, we were expecting 11 votes, and we have received 11 votes. The voting is now closed, and we'll go through the results. For the results, nine percent of worker members voted yes. That does not meet the threshold for recommendation. The Asthma Medication Ratio measure is not recommended by the Workgroup for addition to the 2022 Health Home Core Set. Thanks everybody.

Now why don't we go back to our slides, and we are just about at the end of day one of our voting meeting, so I want to take a couple of minutes to recap today's discussion and preview the agenda for tomorrow.

So, if we could move to -- yeah, slide 61, thank you.

We kicked off our day this morning by revisiting the context for the annual review process, including the measures that were currently in the Health Home Core Set and the measures that were suggested for addition or removal. We also had a great conversation with Workgroup members about their experience about using Health Home Core Set measures to improve the quality of care for health home enrollees.

Then we turned to the discussion of measures suggested for removal. The Workgroup discussed three measures suggested for removal, and two of these measures were recommended by a two-thirds vote of the Workgroup for removal from the 2022 Health Home Core Set, and these measures that were recommended for removal are the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure, and the Screening for Depression and Follow-Up Plan measure.

Then we turned our attention this afternoon to discussing the first two measures suggested for addition, Follow-Up After Emergency Department Visit for Mental Illness and Asthma Medication Ratio. One of these measures was recommended by a two-thirds vote of the Workgroup of the 2022 Health Home Core Set, and that was the Follow-Up After Emergency Department Visit for Mental Illness measure.

Next slide.

Tomorrow, we will finish discussing the remaining measures suggested for addition and vote on those. We will also have a discussion of measure gaps and future directions for the Health Home Core Set, and we will wrap up the day with some reflections on the process of this annual review and opportunities for the Workgroup to provide feedback to our team on improving the review process for future years. And we'll also have opportunities for public comments throughout the day tomorrow as well, just like we did today.

Before we adjourn our meeting, I'd like to give our co-chairs, Fran and Kim, an opportunity to show their reflections on this first day of the meeting and any thoughts as we head into the second day. Fran, do you mind going first?

Sure. I mean, no, I don't mind going first. I thought this was really great. I appreciate everybody's contributions. I actually learned a ton, not only from sort of a national and state perspective but also from an operational perspective, like ‘how hard is it to get the data?’. Also get a sort of better understanding of how health homes are working across the country and in the clinics. I just want to give kudos to everybody for their great contributions and recognize that this is not easy but super important, so looking forwarding to conversations tomorrow and learning more. And have a great afternoon. I'll turn it over to Kim.

Thank you, Fran. I agree with a lot of what Fran said. But I also think that it was a very important discussion, because it really is focused on what is really going to show quality improvement for the populations served in the health homes, and a lot of good discussion on the data that's available to them and the timeliness of the data, that that's also really an important aspect as to consider what measures either add or remove from the core measure sets. And, also, a little bit of focus on alignment, we had just a touch of that today, and maybe we'll get to more of that tomorrow. But really aligning the measures across the different measure sets and where we can actually start to achieve a bigger bang for all of the work that's being done on implementing and measuring quality across all of the different programs. So, everybody did a great job today, and I'm looking forward to tomorrow's discussions as well.

Thank you, Fran and Kim. And I want to extend my gratitude for everyone who joined us today. We really appreciate your engagement and your thoughtful discussion, and your questions, and thank you also to the Workgroup members for working through the voting platform, and to everyone for being so prompt with our agenda and getting back from break.

We will begin tomorrow promptly at 11:00 AM Eastern again, and we hope to see everybody again tomorrow morning. If you have any questions overnight or as you are preparing for tomorrow, don't hesitate a time to reach out to our team, and I hope everybody enjoys the rest of your day, and today's meeting is now adjourned. Thank you.

Thank you.