# 2025 Health Home Core Sets Annual Review:
# Meeting to Review Measures for the 2025 Health Home Core Sets Day 1 Transcript
# July 11, 2023, 11:00 a.m. - 4:00 p.m. ET

**Maria Dobinick:**

Hi, everyone. My name is Maria Dobinick, and I'm pleased to welcome you to the first day of the Medicaid Health Home Core Sets Annual Review Meeting to Review Measures for the 2025 Health Home Core Sets. Before we get started today, we wanted to cover a few technical instructions. Next slide.

If you have any technical issues during today's webinar, please send a message to all panelists through the Q&A function located on the bottom right corner of your screen. If you are having issues speaking during Workgroup or public comments, please make sure you are also not muted on your headset or phone. Connecting to audio using computer audio or the Call Me feature in Webex are the most reliable options. Please note that call-in-only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name on the meeting platform. Next slide.

All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for Workgroup members and the public to make comments. To make a comment, please use the raise hand feature on the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak and remember to lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this webinar. Please use the Q&A feature if you need technical support. Closed captioning is available in the Webex platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Control-Shift-A on your keyboard to enable closed captioning.

And with that, I'll hand it over to Patricia Rowan to get us started.

**Patricia Rowan:**

Thanks so much, Maria. Next slide.

Hi, everyone. My name is Patricia Rowan. I'm a Principal Researcher here at Mathematica and have the honor of serving as the health home lead with Mathematica's Technical Assistance and Analytics Support Team for the Medicaid and CHIP Quality Measurement and Improvement Program, which is sponsored by the Center for Medicaid and CHIP Services. It is my pleasure to welcome you to the 2025 Annual Review of the Medicaid Health Home Core Sets. Thank you so much to our Workgroup members, our federal colleagues, and members of the public who have joined us this morning for this virtual meeting. Next slide.

I want to take a moment to acknowledge my colleagues at Mathematica who are listed here on the slide. This has truly been a team effort to prepare for the meeting, both in terms of content and all the logistical details that go into it. I also want to acknowledge our colleagues at Aurrera Health Group who will be helping to write the report summarizing this week's Workgroup discussion and recommendations. Next slide.

So we have a full agenda and important objectives to accomplish today and tomorrow. And our meeting objectives are listed here on the slide. First, the Workgroup will discuss the one measure that was suggested for addition and the four measures that were suggested for removal from the Health Home Core Sets. Second, the Workgroup will vote on the measures suggested for addition or removal. Third, the Workgroup will discuss gap areas in the Health Home Core Sets and areas for future measure development. This discussion will take place on the second day of the meeting tomorrow, and we'll ask the Workgroup to reflect on gaps that have been raised over the past few years, as well as gaps that remain this year, and to comment on priorities for the future. Finally, we will provide multiple opportunities for public comment today and tomorrow to help inform the Workgroup discussion. I'd like to pause here just for a minute and note that our team is committed to a robust, rigorous, and transparent meeting

process, despite using this virtual format. So that said, we acknowledge that attendees may sometimes experience technical difficulties or challenges with the virtual meeting platform. So I just ask everyone to please be patient as we all do our best to adhere to the agenda and fulfill the objectives of our meeting.

Some of you may also be wondering why we're not using video for this meeting. And as we've mentioned previously, we found in the past that sometimes individuals or locations do not have sufficient internet or Wi-Fi bandwidth to support video. So to ensure full participation by all members of the Workgroup and the public, we want to mitigate technical difficulties that sometimes arise by using video.

I also want to remind the Workgroup members of a few ground rules for participation in today's meeting. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a Workgroup, however, you are all 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 be sure to keep this in mind during the discussion and meeting and voting. Second, we know that spending several hours a day in a virtual meeting can be challenging for all of us. So we ask that you be punctual in returning from breaks so that we can be sure everyone is present for the discussion and voting on the portfolio of measures before us. And related to that, we also want to make sure that all Workgroup members who wish to speak may do so. When you want to make a comment or ask a question, please be sure to use the raise hand feature in Webex and we will make sure you have a chance to speak before we move on. Finally, we want to remind public attendees that we will have designated opportunities for public comment and ask that you please save your comments until we reach that public comment period.

So now I'd like to turn to our Workgroup co-chairs, Kim Elliott and Jeff Schiff, to offer their welcome remarks. Kim, can you raise your hand and we'll be sure to unmute you? All right, Kim, we should be able to hear you now.

**Kim Elliott:**

Hello?

**Patricia Rowan:**

Yep, we can hear you.

**Kim Elliott:**

Oh, great. Thanks. Hi, and another welcome for me from the Health Home Core Set Stakeholder Workgroup meeting. I'm really excited to be here with you today and I'm looking forward to a very active and informed discussion about the recommendations for addition and removal from the Core Set, and I'm sure you are as well. We have had a lot of homework leading up to and preparing for this Workgroup meeting, so I'm really excited to get started. I'm excited to hear everyone's perspectives and their experiences and how they really think and believe after reviewing these measures, how they will make a difference in the quality of care and service delivery for health home participating individuals. We also have an opportunity, of course, to go through gaps and really think through the measures set to see what can really improve it to really measure quality and improve outcomes for the members served in this population. So again, I just want to thank everybody for all of the hard work you've put in leading up to this meeting, and all of the work we'll do the next day or two. And bring that passion, bring that excitement, because it's really an exciting opportunity to really improve care and services for the population served. Jeff, I'll turn it over to you.

**Jeff Schiff:**

Thanks. Quick sound check. Can you hear me?

**Patricia Rowan:**

Yes, we can.

**Jeff Schiff:**

Perfect. Thank you. I want to thank the Mathematica team for all the prep, and I want to say it's an honor to be sitting in this seat as co-chair with Kim. I did a little thinking about what to say at this moment, and I realized I wanted to look at some numbers. So 28 percent of the U.S. population is covered by Medicaid as of March. With the unwinding, that may change some, but it's still a significant amount of our fellow citizens. There are 33 health home models in 18 states [and the District of Columbia], and all of those are really geared towards supporting individuals in Medicaid with chronic disease. And I keep on going back to the six core services. I think that this program has been around since the Affordable Care Act, and it's the only section of the Affordable Care Act that I know by number, 2703 and now 1945A. And our work today, I think, is even more important because mandatory reporting adds weight to our decisions. This is the program at Medicaid where we go from -- it sits between the state and the provider level, so it's really a program health system community thing. And I think, similar to what Kim said, I think we really have a big responsibility here to think about measures that will actually improve quality and outcomes, and whether or not the measures we're selecting or deselecting are the correct fit for purpose. What's the balance of the information we gain and the burden, and how will our measures move healthcare forward? So I'm looking forward to a very exciting couple days, and I will turn it back over to the Mathematica team. Thank you.

**Patricia Rowan:**

Thank you both. Next slide.

So at this point, we will introduce the Workgroup members and any disclosure of interests. Next slide.

So to ensure the integrity of the review process, we ask 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 measure that will be reviewed by the Workgroup for potential addition to the Health Home Core Set. So during the introductions, Workgroup members will be asked to disclose any interests related to those measures that will be reviewed by the Workgroup. Next slide.

We are going to do a formal roll call today for the Workgroup members. So as I go through the roll call, I ask Workgroup members to please use the raise your hand feature in Webex when your name is called. That way we will be able to unmute you, and you can say hello, share any disclosures that you have, or indicate if you have nothing to disclose. We also have an icebreaker to start off our meeting, so we'd like you also to briefly mention one thing that you are looking forward to during this week's annual review. When you're done with your introduction, please mute yourself in the platform and lower your hand. This will allow you to mute and unmute yourself when you would like to speak during the measure discussions. If you have to leave and reenter the Webex or you find that you have been muted by the host due to background noise, just raise your hand again, and we will unmute you. Next slide.

So on these next two slides, we have listed the Workgroup members in alphabetical order by their last name. So when I call your name, please raise your hand so we can unmute you. If you are also muted on your headset or phone, please remember to unmute your own line to avoid the dreaded double mute. And if you have any technical issues, please use the Q&A function for assistance. So Kim, we will start with you. Please indicate whether you have a disclosure and mention something that you are looking forward to during this year's meeting.

**Kim Elliott:**

Hi. I do not have anything to disclose, and I think what I'm looking forward to the most in this meeting is really hearing the differences in each of the Workgroup's perspectives and the expertise that they bring to the discussion on each of the measures we're discussing, either for addition or for removal. Oftentimes I hear things that make me rethink how I felt about a measure just based on someone else's expertise or experience that may differ from my own. So that's what I'm looking forward to.

**Patricia Rowan:**

Thank you. Jeff.

**Jeff Schiff:**

Hello again. Jeff Schiff. I'll just introduce myself by saying I'm a senior scholar, Academy Health, a pediatrician, and a former Medicaid Medical Director. I have nothing to disclose. I am looking forward to the robust discussion and the expertise in the group, and I'm also looking forward to the gap discussion that we'll have tomorrow. Thanks.

**Patricia Rowan:**

Thanks, Jeff. Carrie.

**Carrie Amero:**

Yes. Can you hear me?

**Patricia Rowan:**

Yes, we can.

**Carrie Amero:**

Great. So I'm Carrie Amero. I'm with the AARP Public Policy Institute, focused on long-term services and supports. And I do have something to disclose. I worked previously at the Lewin Group, and I left that job in the fall of 2020. But while I was there, I was a member of the team that Lewin had working for CMS to develop and maintain certain home and community-based services measures, which included some focused on, I think, three of the MLTSS measures, one, two, and four, I believe. But the task that I actually worked on was not related to MLTSS-2. I worked on helping states with implementation of the HCBS CAHPS tool. So I don't think it's really a conflict of interest, but I did want to be sure to disclose that. And I am excited, I think, particularly about the discussion, it sounds like it will happen tomorrow, about what's going on, kind of current landscapes and current needs. I'm really looking forward to that.

**Patricia Rowan:**

Thank you very much, Carrie. David? Derek, can we unmute David? There we go. Thank you.

**David Basel:**

David Basel. I'm a Population Health Officer for Avera Health Integrated Health Systems in the Northern Plains. I do not have anything to disclose. Probably what I'm looking forward to most as a quality professional is mainly the process of continually reviewing these measures and seeing if we can improve upon them. And that's what we do as quality folks. So I appreciate the opportunity to participate.

**Patricia Rowan:**

Thank you, David. Jay Berry. Jay, can you unmute yourself?

**Jay Berry:**

Hi, guys. Jay Berry here. I'm a general pediatrician and health services researcher at Boston Children's, and I'm the Chief of Complex Care. We have a health home here of around 4,000 children with medical complexity. Nothing to disclose. I'm looking forward to the process and working with you guys, especially Amy Houtrow, who I find absolutely delightful.

**Patricia Rowan:**

Thank you. Dee?

**Dee Brown:**

Hi. I'm Dee Brown. Glad to be here. Nothing to disclose. And I am looking forward to several things, but primarily the priorities for the future dialogue, and honored to be here with all of these bright minds. So thank you.

**Patricia Rowan:**

Thanks, Dee. Stacey?

**Stacey Carpenter:**

Hello, everyone. I'm Stacey Carpenter. I have nothing to disclose. And I'm just looking forward to being able to share any insights I might have and learn from other expertise for today.

**Patricia Rowan:**

Thanks, Stacey. Macy Daly.

**Macy Daly:**

My name is Macy Daly. My real name is Mackenzie, which is why it appears that way. I work for the Rhode Island Department of Behavioral Health Care Developmental Disabilities and Hospitals, and I'm part of the data unit, and we report on OTP health homes as well as the community mental health homes. And I'm just excited. I've been reporting this data for five years now, and it's exciting to be on the other side and get to have a part in some of the discussions, and also just always looking forward to learn something from another state or another entity who reports to the system, because there's always more to learn and improve. So thanks. Nice to meet everybody.

**Patricia Rowan:**

Awesome. Amy?

**Amy Houtrow:**

Hi, everyone. My name is Amy Houtrow. I'm a pediatric rehabilitation medicine physician and health services researcher for children with disabilities at the University of Pittsburgh. I have nothing to disclose, although I suspect now I probably owe Jay Berry about $100 for saying something nice about me. I have

been excited about learning from other people's perspectives as we go through this process, so I'm really grateful to be a part of it.

**Patricia Rowan:**

Great. Thanks so much. Next slide. And Raina, we'll continue with you. Derek, can we unmute Raina? Derek, are you able to unmute Raina Josberger?

**Derek Mitchell:**

I just unmuted Raina.

**Patricia Rowan:**

Raina, you might still be muted on your phone or headset. Okay. Why don't we come back to Raina? And we'll go to Arielle.

**Arielle Kane:**

Hi, everyone. Arielle Kane with Families USA. I don't have anything to disclose, and this is my first time participating in this group, and so I'm just really excited to be a part of the discussion. It's great to be here.

**Patricia Rowan:**

Thank you. Raina, it looks like we've solved your audio issue.

**Raina Josberger:**

I'm unmuted. Thank you. Hi, I'm Raina Josberger. I work for the New York State Department of Health. I do not have anything to disclose, and I'm just looking forward to meeting you all and working with you over the next two days. I'm excited to hear about what's to come, so thanks for having me.

**Patricia Rowan:**

Thank you. And Pamela Lester.

**Pamela Lester:**

Hi, I'm Pam Lester with Iowa Medicaid. I'm a quality manager and support the health home program here. We have two state plan amendments, a physical health and a behavioral health. I'm excited to be here to continue to improve the measures that we report to CMS and really learn perspectives from other people on these measures. Thanks for having me.

**Patricia Rowan:**

Thank you for being here. Amy Salazar. Derek, I believe we're going to unmute Amy's phone, call-in user.

**Derek Mitchell:**

Okay, Amy's line should be unmuted.

**Amy Salazar:**

Good morning, everyone. Can you hear me?

**Patricia Rowan:**

Yes, we can. Hi, Amy.

**Amy Salazar:**

Okay, great. Hi, I'm Amy Salazar. I'm the Deputy Bureau Chief of Quality for New Mexico Medicaid. I don't have anything to disclose, and I am looking forward to finding out what challenges or what other challenges that we can relate to with data collection for the health home measures. So thanks, everyone. It's an honor to be here.

**Patricia Rowan:**

Thank you. Sara Toomey. Derek, can we unmute? There we go. Sara.

**Sara Toomey:**

I'm a general pediatrician and an SVP Chief Safety and Quality Officer up here at Boston Children's. I have nothing to disclose, and I think what I'm most looking forward to is the conversation about gaps tomorrow and specifically through the sort of pediatric lens. So thank you for letting me contribute.

**Patricia Rowan:**

Thank you for being here. Laura Vegas.

**Laura Vegas:**

Good morning, everyone. I'm Laura Vegas with the National Association of State DD Directors. I have nothing to disclose, and along with my colleagues here, looking forward to the robust conversation and really enjoy hearing perspectives of this diverse group around quality measures, especially as it impacts the health home model.

**Patricia Rowan:**

Great. And Jeannie.

**Jeannine Wigglesworth:**

Hi, this is Jeannine Wigglesworth. I am the Director of the Behavioral Health Homes here in Connecticut. I work for Carelon, which is the ASO for the Behavioral Health Medicaid, and I'm representing the Department of Social Services for Connecticut. And I have no disclosures, and I am very much looking forward to hearing about any barriers people are experiencing around calculating some of these measures and how they've been kind of addressing that. So very happy to be here. Thank you.

**Patricia Rowan:**

Great. Thanks, everyone, for joining. Next slide.

So we are also joined today by federal liaisons who are non-voting members of the Workgroup. I am going to read the names of the agencies that are represented but not do an individual roll call. So we have the Administration for Community Living, the Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality at CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, the Office of Disease Prevention and Health Promotion, the Office of Minority Health, and the Substance Abuse and Mental Health Services Administration.

So federal liaisons, if you have questions or comments during the Workgroup discussion, please raise your hand and we will unmute you. And I would also like to take the opportunity to thank our colleagues in the Medicaid Benefits and Health Programs Group at the Center for Medicaid and CHIP Services, as well as the measure stewards who are attending this week's meeting and are available to answer questions about the measures being discussed. Next slide. So now I would like to introduce Sara Rhoades, the Technical Director of Health Homes at the Medicaid Benefits and Health Programs Group in the Center for Medicaid and CHIP Services, to make some welcome remarks on behalf of CMCS. Sara, if you could use the raise your hand feature, and Derek has unmuted you, it sounds like the floor is yours.

**Sara Rhoades:**

Can everyone hear me all right?

**Patricia Rowan:**

We can, yeah.

**Sara Rhoades:**

All right. So welcome, everyone. I am just really impressed by everyone's background, going through those names, and all the different types of programs that everyone is part of. And I think this is just a really good crosscut of people that would be part of health homes or contribute to these quality measures. So I just appreciate everyone being on the call today. A few things I did want to mention, one being that we actually have two more states that are not reflected on our website that were recently approved, and that's Idaho and North Carolina. And both of them had health homes previously, and they've come back in with health homes. So I think that that's important to note, that they're using this model again after terminating it previously.

But more importantly, both of the new programs are focusing on the IDD population and the SMI population. And we are seeing an uptake in interest of this particular model for that IDD population. So it's just something to keep in mind as we talk possibly tomorrow about gaps and things. This is kind of a population that was historically more under 1915(i) waiver-type programs, and we're seeing an interest in more health homes having this population added. And so, also, speaking towards tomorrow as we're looking through gaps and things like that, just a few key things that CMS is really focusing on is equitable care, stratification of measures, where we could get to a place where we could possibly stratify some of these measures, and looking specifically for health homes at measures that can really get obtainable data at a program level, and then, of course, burden to any providers and states as we move towards the possibility, very real possibility of mandatory reporting as our rule is moving. So again, those are kind of some key highlights of things that CMS is focusing on, and I just appreciate everyone being on the call today and participating to help us better be informed to make decisions around these quality measures. Thank you all.

**Patricia Rowan:**

Thanks, Sara, for being here. And now I would like to turn it back to my colleague, Maria, to kick off our first discussion for today.

**Maria Dobinick:**

Thanks, Tricia. Next slide.

Before we review the measures today, we'd like to dedicate some time to discuss a gap in the Health Home Core Set mentioned by the Workgroup in previous annual reviews, and that is measuring screening and referrals for social drivers of health. As we mentioned during the June 13th meeting to

prepare for this week's annual review, the Screening for Social Drivers of Health, or SDOH-1, measure was suggested for addition to the 2025 Health Home Core Set. However, this measure will not be discussed by the Workgroup because it did not meet minimum technical feasibility criteria for testing or use in one or more state Medicaid and/or CHIP programs. But we know this topic is a high priority, and we wanted to set aside time to hear from Workgroup members about how health home programs are screening enrollees and making appropriate referrals for social drivers of health, and how they are capturing information on screening and referrals. We hope this discussion will open up future opportunities for quality measurement through the Health Home Core Sets. Next slide.

As you likely know, Medicaid health home programs are designed to provide comprehensive care coordination to beneficiaries with chronic conditions. As such, understanding the whole person and providing person-centered care within the context of a health home enrollee's full range of medical, behavioral, and long-term services and supports are key elements of health home program design and implementation. One of the six core services that must be provided by health home programs is referral to community and social services. Screening, identification of needs, and referrals for health home enrollees based on social drivers of health is one way that states can address this requirement of health home programs. Next slide.

To help us set the stage for the conversation, we've listed a few topics on this slide for Workgroup input and discussion. First, how are health home programs and providers currently screening health home enrollees for social drivers of health? And what are the challenges with current screening approaches? Next, how are the outcomes of SDOH screenings being measured? And once enrollees are screened, are the results captured in data systems? Are referrals tracked? If so, how? Are screening and referral data shared by providers with the state for the purposes of health home program monitoring or quality improvement? What additional resources might states need to advance the screening and referral for SDOH among health home enrollees? How might we capture this information for quality measurement? And finally, are there any other key considerations for advancing this work? Next slide.

At this point, I'd like to open it up for Workgroup members to share their perspectives. We'll start with Jay Berry, followed by Stacey Carpenter, Raina Josberger, and Jeannie Wigglesworth. Please remember to unmute yourself to speak and raise your hand if you need to be unmuted. Jay, if you could raise your hand and Derek will unmute you. Okay, Derek, there we go.

**Jay Berry:**

Great. Thank you, guys, for putting this on the agenda and putting it up front. Even though we're not going to be reviewing measures associated with this today, I think it's so important and hopefully over time we'll be able to incorporate something. My perspective and experiences are from the pediatric side and caring for children with complex medical needs, lots of multi-morbidity, use of durable medical equipment supplies, polypharmacy, and the families of these children experience a large amount of caregiving effort and burden, and they're at risk for adverse childhood experiences and lots of social-related challenges. So as a result, in our health home practice, you know, we have four social workers that are embedded into our inpatient and outpatient programs that recurrently screen patients and families trying to assess these things.

We have used a screener adapted from the Virginia Commonwealth University health system of what they use, which we like. It's also a bit of an amalgamation with some of the National Survey of Children's Health questions, which we find very appropriate for screening. But it includes all the routine things you would think about, transportation, housing, food, utilities, health literacy, insurance, education, family support, isolation, marriage, employment, and also just ask in general about family well-being and quality of life. So we try to implement this screener, which we do through some pre-visit work and also in person or virtually with the families at least once a year and recurrently if we feel like that's needed, and then try to act on it with the things that we have that we can try to take action on the findings. I think that's the most challenging part. It's easy to screen and detect problems, but it's much harder, I think, to dig in with

the families and actually come up with solutions that allow them to overcome some of the challenges that they're experiencing. So we feel like this is a key ingredient of a health home, and it's something that should be promoted for a health home, achieving high-quality care and delivery.

**Maria Dobinick:**

Thank you, Jay. Stacey, if you can raise your hand, please, so Derek can unmute you.

**Stacey Carpenter:**

Hi there, everyone. I'm Stacey Carpenter. I'm representing New York State, but I also wanted to give some context that I also previously worked a network of federally qualified health care centers, so my experience for today is based on both of those roles. We all know there are disparities in access to quality care for children.

[Inaudible]

**Maria Dobinick:**

Stacey, your sound quality is breaking up a little bit.

**Stacey Carpenter:**

I'm not sure what to do about that. Does it sound better now?

**Maria Dobinick:**

It does.

**Stacey Carpenter:**

Okay. The SDOH factors can severely exacerbate their conditions and family dynamics. So if we're not universally screening to determine these factors, we will never know how best to support and assist the families. Universal screening provides the consistency of asking, so you're not missing the families you'd never expect to be struggling with issues. Another consideration to think about is adding any new screener of any kind is challenging for families and for any health program. So it's essential to really think about having an implementation team that represents the whole system, making sure you're discussing workflows, how to establish those roles to hand out the screener, for example, to assess what was indicated on the screener and make sure that you're addressing anything that was elevated. Having the whole system represented at the table of decision-making is also where you're going to have that buy-in, where all the staff are willing to work on this issue.

Just thinking back to when I worked at an FQHC and we were initially rolling out the SDOH screening, it was a challenge because a lot of staff were confused of why we were doing this and couldn't really help families. Once they were able to see how much families were struggling and knowing we could provide assistance made a world of difference. Another consideration to think about is that specific to the families themselves, they're not always willing to be honest about what struggles they're having for a variety of reasons. It could be that they're embarrassed. They might think if they answer the screener in a certain way that you might take their children away from them. So there's a lot of different factors. But when you make it universal and you make it something that they're asked multiple times, you're more likely eventually to get the honest information to be able to assist the families.

And so just ending on thinking about implementation process of SDOH screening, the health system needs to evaluate how to collect that data, and I think that's a big challenge for many folks is how are they

going to put that information into their EHR and how are they going to be able to extract that. And that definitely needs to be a part of the implementation process. Otherwise, you're not going to be able to see what the family's needs are, as well as being able to see the themes of what the families might need throughout your health system to ensure that you can then address maybe larger system problems that are in the community that the families live in.

**Maria Dobinick:**

Thanks so much, Stacey. Raina, you're up.

**Raina Josberger:**

Hi, everyone. Since the fourth quarter of 2020, New York has been collecting the first questions of the Accountable Health Communities health screening assessment information from the adult health home population. And this information is reported to us by the health homes annually. It includes the questions around living situation, mold and lead, as well as into food insecurity, utilities, transportation, and other safety concerns. So we do have preliminary information on that, and that is collected by us through our own care management type of systems from the health homes to us. As far as tracking, that is work that's ongoing and being developed within the department for the health home population as well as the wider Medicaid group. That is more work that we have coming to actually ensure that that referral is being addressed and closed. So a lot more work to come there. But we do have some preliminary work ongoing in this situation.

**Maria Dobinick:**

Thanks so much, Raina. Jeannine.

**Jeannine Wigglesworth:**

Hi, there. For Connecticut, we have 14 behavioral health providers. Our health home is focused on the SMI population, and each provider does track different components of social determinants of health in different ways. However, you know, collected individually in their own EHRs. There are certain components, though, however, that is universal that come to us at Carelon. Carelon is kind of like the universal. We collect all the data, and then I'm distributing the data back to the 14 providers through Tableau. And some of those are, one, through DMHAS, the Department of Mental Health and Addiction Services, that kind of oversees all the providers, they have a section on housing and employment that gets directed to me, and I develop a report that gets sent back out to them.

And also, we at Carelon are able to collect data through claims. We are using the CCRS -- the CCSR, I'm sorry, categorical system for the social determinants of health. And we look at the first four dyads in claims, and we are also looking at DMHAS data for that as well. So the only problem is because those claims, you know, they're not billable, they're not really being entered. So for the total Connecticut Medicaid population, we're only seeing about 3 percent of people entering, you know, of the Medicaid population in there, which we know is much higher. And if I look at the health home population, it's about 9.5 percent. So that would be the barrier of using claims for that. And we have definitely a robust way of identifying homelessness through several different methods, through our diagnostic codes, as well as through our own authorizations, through addresses, and through the Connecticut HMIS system as well.

But looking at the social determinants of health assessments that were given in the research materials that you guys indicated is definitely something I think as a health home here in Connecticut that we would be very interested in looking into. It would just be how we would gather that data and bring it back to Carelon to evaluate. We are able to evaluate through claims, you know, population health or BHH on a larger scale. So you know, using those social determinants of health claims variables, you know, I can look at things like, you know, those with an SDOH indicator, you know, they spend approximately like

$13,000 more per member per year than the average BHH member. They utilize the ED 29.6 percentage points more than the average BHH member. They go inpatient 34.8 percent points higher than the average BHH member, and things like that. So we are able to kind of utilize some of it, but I think those assessment tools or universalizing some of those assessment tools that are different for two provider views would be very beneficial.

**Maria Dobinick:**

Thank you all so much. Next slide.

Now we'd like to open it up for other Workgroup members to share their insights and experiences with screening and referrals for social drivers of health. Next slide.

As a reminder, here are several discussion topics for you to consider. Please raise your hand if you wish to speak, and I will call on you in turn.

I see Dee Brown with her hand raised. Derek, if we could unmute Dee, please.

**Dee Brown:**

Hi. Thank you for recognizing me. I neglected to say that I oversee, at a national level, four managed care programs in New York, Missouri, Minnesota, Washington, in California when it was there, very familiar with North Carolina when it was there, and Hawaii is considering a program now called the Hale Ola Program. So I come from that perspective and wanting to talk about the difficulties that health homes have in administrative burden in every market. And I think one of the biggest things for us to think about now with SDOH is standardized recommended tools that would be interoperable in an electronic health record. And I would recommend that the MIPS program today that is looking at the measure that is today under Medicare only, one of the recognized things that was needed was training for the providers.

And I would ask that that continue in depth, because we could do this with less administrative burden, with that interoperability standardized that are affiliated with the comprehensive assessment already in health home programs, and training for providers on how to do Z coding or CPT-II capture coding because providers aren't getting paid for those services. And to that end, some of the standardized technology solutions for doing the referral capture, which is very difficult for anybody to capture. There are standardized technology solutions out there for referrals, but also the community-based organizations that provide the social services referral supports are underfunded.

And so in thinking through an end-to-end opportunity is how do we have interoperable technology solutions that are easy to use, integrated, and also could provide reimbursement mechanisms for the CBOs providing the referred services for food banks or for housing support. California did a very good job in adding housing into their health home program in that market and having those services being able to be captured.

Finally, the last thing I will say is consent from a member and sharing their data was a big hurdle, even in multiple markets because of sensitive conditions primarily served in health home programs. So your SUD population, in some market sensitive conditions in some states, they're heavily regulated for SMI, and SUD. And so really considering how do we capture and help families understand the importance of us being able to help them when they share their data. So that's pretty much what I wanted to say. And I do think that there's an opportunity here to figure out how to stratify this data. But we need to have the proper coding and ease of administration. And I think the technology burden is the biggest piece. So many of our health home care managers struggle with the amount of administrative paperwork, and we need to do a better job to support them doing a very, very difficult high-burnout role and responsibility in every way that we can so that they can be successful in doing their jobs.

**Maria Dobinick:**

Thank you so much, Dee. Amy Houtrow, I see you next. Derek, if we can unmute Amy. Derek, can we unmute?

**Amy Houtrow:**

There we go. We got me unmuted. Thank you. This is Amy Houtrow. I really appreciate the points that folks have made just now. And my own experience is that when we're doing screening for social determinants of health, it puts our patients and families in a very vulnerable position where they're often sharing with us things that they feel guilty or shame about. And for me, measuring those social determinants of health and opening up those kind of wounds for families, it's not worth it unless we have a strategy to act upon them. And I really appreciate the point of how much administrative burden, how there's not reimbursement and all the work that has to go into arranging supports and services.

And from a family's perspective, they also experience a lot of burdens of paperwork and appointments and trying to access services they need. And those are often very temporary and have to be re-enrolled. And families tell us that they would like one point of entry. So a family who is food insecure probably also has other factors that are impacting their lives related to poverty, such as transportation. And so as we're thinking about this, I want us to think both about kind of the perspective of the system with all of its added administrative burdens and systems not talking to each other, and then how that really impacts families as well as in a very negative way. And so we measure our social determinants of health and then consider ourselves successful if there's been an engagement with the social worker or somebody to get services rolling. And that's a really low bar, you guys.

It's not one that I'm very comfortable with. And I do think it will really be helpful for us to talk about what it takes for us to say we've done the thing we've needed to do to help these families be successful in this space. Because I just don't think that we've come as far as we need to come on really assessing the outcomes of the screening instead of just saying, yes, we've screened. And I think this point about tracking referrals and how challenging it is to track referrals and make sure something has happened and the work required both for the families and for the administrators and clinicians to do this is just a really phenomenal amount of work. So I'm looking forward to the discussion of how we simplify access, what sort of resources are necessary to do that, how we can make things much more easy-to-use and simplified so that all of us, you know, are feeling like we can be more successful and de-burdened by this work.

**Maria Dobinick:**

Thanks so much, Amy. Jeff, I see you're next.

**Jeff Schiff:**

I also appreciate the previous comments. I wanted to say that I'm glad we're not considering this right now because I don't think we're ready for primetime, even though it's a huge need. I think just to add a few more points to what has already been said, I think that we have to really pay attention to how screening gets done for the same reasons that Amy talked about, about people feeling vulnerable. Screening done by somebody in a community that's trusted may be much more effective. So how often it gets done and by whom, I think we need to pay attention to that as we think about whether there's a measure we want to put here or not. I also want to think about this. We have screening as a deficit thing and we don't have screening as an asset. So there may be protective factors, especially for children, you know, and families that we may want to look at as well. And I think we have to think about whether the goal of screening and reporting in the Health Home Set or in the national Core Set is really about helping families specifically or about surveillance.

So I really think that if we're doing this for surveillance, there's other ways of doing it and we ought to label it that. And if we want to do it to help families, we should do that as well. And then the other thing I just want to add to this is I think there are some types of screening that we could do through claims. Jeannie from Connecticut was really talking about homelessness indicators. We did something like that in Minnesota where we can get some data, find out where our population is at without, you know, without actually going and asking. And I think that that would be really worthwhile. So in the end, I think we need to, before we roll this out as something we ask people to do as a screening and maybe a connection to referral, we have to figure out, be really sensitive to how it impacts families and how we move resources, including financial resources, to folks who can really do something about this. So thank you for having this discussion.

**Maria Dobinick:**

Yeah. Thank you so much, Jeff, for all those comments. David, I see your hand up. Derek, if we can unmute David, please.

**David Basel:**

Yes. Thank you. David Basel here. And from a health system standpoint, you know, as we're trying to capture this information, I would also agree we're probably at least a couple years away from this being a legitimate thing to add to the health home requirements, because there's so many pieces of this to figure out. And one of the pieces I'm really interested in following, you know, to try to get around, you know, having your lowest-paid employee at the front desk ask these questions or adding to the burden of nurses asking these questions at clinic intake, you know, ideally you would do it through a portal questionnaire or something like that. But, you know, the concern there is, are the people that you're most likely to not get access to a portal questionnaire the people you most want to know this information on?

And so being able over the next couple of years to understand the advantages and disadvantages of different screening mechanisms as we, you know, as some of these requirements get handed down by CMS, we're going to be learning a lot in this field about what works and what doesn't. And so I imagine it's going to be an ongoing discussion. And I also agree that it's going to be very challenging without some sort of additional reimbursement. And it is a significant burden trying to capture this type of information and what's competing priorities at intake and stuff. To do it well is going to be challenging on an already money-losing visit.

**Maria Dobinick:**

Thank you, David. Macy, I see your hand up. Derek, if you could unmute her, please.

**Mackenzie Daly:**

Yeah, I can speak more from like the purely data side because I'm on the data collection side, less of the kind of health things, but we do collect a lot of the kind of social determinants of health data.

**Maria Dobinick:**

Macy, you are breaking up a little bit. If you can get closer to your mic or maybe move to a different location, if you're on a cell phone.

**Mackenzie Daly:**

It'd be better here on my laptop.

**Maria Dobinick:**

Yep, that's better. Thank you.

**Mackenzie Daly:**

Yeah, so we do collect a lot of the social determinants of health data in our behavioral health care system that we use for SAMHSA reporting. But we do find that one, it's difficult to get updates in the system, so we tend to get mostly the information at intake. So it's hard to see if we're seeing improvements in some of those areas, like employment and housing in particular, are two that we focus on heavily. And then the other thing is when we do get those updates, it's very difficult to kind of capture that data, at the individual level, you know, X percent of people, became employed during this time, that is very difficult to extract from our system. So it's kind of like challenges on both sides, administratively, I think both for us and for our providers to really track this in a way that allows us to see somebody through the system and see the impact of the programs on these determinants of health that we know are so important for people to live a fulfilling life. So yeah.

**Maria Dobinick:**

Thanks for those comments, Macy.

Anybody else from the Workgroup have insight, comments, questions at this time? Does anyone want to make a second comment or speak again, follow up maybe on some of the other things they heard? And Macy, I can't tell if you want to speak again or if your hand is still raised from before. There we go. Thank you.

All right. Last call for Workgroup members. All right. Next slide, please.

Thank you so much to the Workgroup for that really robust discussion. And now we will open it up for public comments on this topic about screening and referrals for social drivers of health. If you wish to make a comment, please raise your hand and we will unmute you in the order in which your hand was raised. Please make note that we are not taking public comments through the Q&A function. And please also make sure to identify yourself before you speak. So at this time, we are open to public comments.

Peggy O'Brien, I see you. Derek, if you could please unmute Peggy.

**Peggy O’Brien:**

Can you hear me?

**Maria Dobinick:**

Yes, we can.

**Peggy O’Brien:**

Okay, great. This is Peggy O'Brien from SAMHSA. I really appreciate this discussion and I appreciate the fact that the proposal of the measure for inclusion, while not taken under consideration, has prompted this level of discussion. And so what I am really looking forward to is following, as there is follow through, on the discussion and the problems that have been identified. I think this is incredibly important. It has been identified as a gap for a number of years. And it is dismaying but understandable that it is very hard to get it moved forward.

**Maria Dobinick:**

Thank you so much, Peggy. Do we have anybody else who wants to make a public comment? I also want to acknowledge our partners, our federal liaisons, if anyone there wants to make a comment or ask a question. Remember, if you want to make a comment or have a question, you can use the raise hand feature and I will call on you.

Okay, I see Dee has her hand raised again. Derek, go ahead and unmute Dee.

**Dee Brown:**

Yes, I was just thinking, is screening something states would consider at Medicaid applications so that the information would be captured up front and then measured later? And I am wondering if folks from either state systems or Medicaid systems would consider that this is something that could be asked during the Medicaid application phase.

**Maria Dobinick:**

Thanks for that, Dee. Is there anybody who wants to comment, answer, have thoughts on Dee's question? All right, Jeff, I see your hand up.

**Jeff Schiff:**

I think one of the opportunities here is that some states are looking at universal application for social and medical services. So you know, suggesting or tracking what states are doing, some sort of a universal application that looks at SNAP and housing support, you know, would be an opportunity to get a fuller picture of where families are at.

**Maria Dobinick:**

Thanks, Jeff. Anybody else? All right. I think this is a last call for Workgroup members, federal liaisons, those public who are listening in today.

Last call for comment, you can raise your hand. All right. Well, thank you, everyone, for that really robust discussion and all of the comments. Next slide, please.

Before we take a break, we would like to ask Workgroup members to use part of the break to prepare for voting. We will be doing some live test votes after the break. So please take a few minutes during the break to log into the Slido voting platform and make sure you can see the test question we have posted. You can use either your computer or a mobile device.

Please note you will need access to the email address where you receive your Core Set correspondence, as you will receive a code from Slido to access the section where you cast your vote. You may also want to keep the Slido voting platform window open between votes to avoid the process of reconfirming your identity to cast your vote. If you have any issues, please reach out to us through the Q&A or the mailbox during the break and we'll work to resolve your issue. And with that, we will take a break. We will return from the break at 1:10 Eastern Time. Thank you. Next slide.

## BREAK

**Maria Dobinick:**

Hi, everyone, and welcome back from the break. We're going to start the measure discussion shortly. But first, we'll describe the approach to the measure review and do some practice voting. Next slide.

I'll provide a quick recap because most of us were together just three weeks ago during the Workgroup meeting to prepare for voting. But for folks who might be seeing this for the first time, the slides and other background materials are available on our website.

The Medicaid Health Home Core Sets Workgroup for the 2025 Annual Review is charged with assessing the 2023 and 2024 Medicaid Health Home Core Sets and recommending measures for addition or removal in order to strengthen and improve the Medicaid Health Home Core Sets. The Workgroup should focus on recommending measures that are actionable, aligned, and appropriate for program-level reporting to ensure the measures can meaningfully drive improvement in quality of care and outcomes for Medicaid health home program enrollees. Next slide.

As we have done in the past, we wanted to share this slide, which highlights the balance that Workgroup members face in assessing measures in terms of their feasibility, desirability, and viability. Our goal in this year's review is to optimize the overlap of these three elements, technical feasibility of collecting and reporting measures, desirability of measures, which relates to their actionability and strategic priority, and financial and operational viability, such as alignment across programs and state capacity for reporting, particularly at the program level. There are many good quality measures, but we need to keep in mind that the measures must be good for use in program-level quality measurement and improvement for Medicaid health home programs. We also give an example of the types of tradeoffs that Workgroup members should consider. While outcome measures may be more desirable to stakeholders than process measures, the Workgroup also needs to consider the feasibility and viability for program-level reporting. For example, quality measures that reflect health outcomes may be more desirable than process measures, but they may be more challenging to report based on data availability and resource intensity. Next slide.

For many of you, this graphic is familiar. It is a visual representation of the concept of multilevel alignment of quality measures. At the bottom, we have measures at the clinician or practice level, which feed into measures at the program, health plan, system, health system, or community level. Health Home Core Set measures are considered program-level measures because they are for distinct subpopulations within the state's Medicaid program. The Child and Adult Core Set measures are considered state-level measures because they are intended to capture all Medicaid and CHIP beneficiaries within the state. State-level measures can then be aggregated to the national level for monitoring the CHIP and Medicaid program as a whole. CMS values alignment of quality measures across programs and levels because it can help drive quality improvement by addressing each level of care so that improvement at one level may lead to improvement at other levels. Moreover, alignment is intended to streamline data collection and reporting burden. Next slide.

Now we will share a bit more information about the Health Home Core Sets overall to provide high-level context for these measure discussions. The 2023 1945 Health Home Core Set includes 13 measures. There is no target number of measures, either minimum or maximum. We encourage Workgroup members to consider each measure on its own merits according to the criteria. In terms of reporting on the 1945 Health Home Core Set, federal fiscal year 2020 is the most recent cycle for which data are available. Of the 37 approved health home programs expected to report, 34 reported at least one measure. States reported a median of nine measures, and reporting remained consistent or increased for 24 of 26 health home programs that reported for all three years from FFY 2018 to FFY 2020. Reporting increased for all nine measures included in both the 2018 and 2020 Medicaid Health Home Core Sets. Next slide.

It is important to note that measure stewards typically update various aspects of a quality measure's technical specifications each year. Changes can reflect a variety of factors, such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users. We have done our best to reflect the most accurate and up-to-date information about each measure. The measure information sheets, which are available on our website, reflect public information and information from

measure stewards as of May 2023, though it is important to note that measures may undergo additional updates between now and when the measure specifications for 2025 reporting are finalized. Next slide.

I'll wrap up this section with some additional context for this year's review. As you may recall, during the orientation meeting, we introduced a new health home state plan option to establish health home programs for children with medically complex conditions. These are known as 1945A health home programs. As of June 2023, no states have submitted a state plan amendment, or SPA, to implement a 1945A health home program or requested a planning grant. During the orientation meeting, we also shared the proposed 2024 1945A Health Home Core Set. During the call for measure period, the Workgroup did not suggest any changes, removals, or additions to the proposed 2024 1945A Health Home Core Set. Therefore, all measures being discussed today and tomorrow are under consideration for addition to or removal from the 1945 Health Home Core Set only. Next slide.

Now we're going to shift gears a little bit and talk about the criteria for reviewing measures and share some voting logistics. Next slide.

In each meeting, we always come back to our established criteria in these three areas for assessing measures: minimum technical feasibility, actionability and strategic priority, and other considerations. We know many of you have seen these slides several times before. However, we have some new Workgroup members and public attendees, and the criteria are foundational to the discussions over the next two days. To be considered for the 2025 Medicaid Health Home Core Sets, all measures must meet minimum technical feasibility requirements. Next slide.

As I just mentioned, the first category is our minimum technical feasibility requirements. All suggested measures must meet these requirements. So the measures we'll discuss today and tomorrow have passed through Mathematica's initial screen based on these criteria. This means that the measures should be fully developed and have detailed technical specifications for producing the measure at the program level. They have been tested in or are in use by at least one Medicaid or CHIP program, have an available data source or validated survey that includes an identifier for Medicaid beneficiaries, and their specifications and data source allow for consistent calculations across states. CMCS also requires that the measure must include technical specifications, including Core Sets, code sets that are free of charge for state use. However, Workgroup members do not need to worry about that.

The second category is actionability and strategic priority. Measures are recommended for addition to the Core Set, and they should contribute to estimating the overall national quality of healthcare in Medicaid health home programs and performing comparative analysis of disparities. They should address a strategic priority in improving healthcare delivery and outcomes, and can be used to assess state progress in improving healthcare delivery and outcomes in Medicaid and CHIP.

Finally, a few other criteria to consider. Is the prevalence of the condition or outcome sufficient to produce reliable and meaningful results across health home programs? Is the measure aligned with those used in other CMS programs? Will all health home programs be able to produce the measure within two years of the measure being added to the Health Home Core Set? Next slide.

When Workgroup members are discussing measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. So for example, we ask the Workgroup to consider, is the measure no longer making a significant contribution to estimating the overall national quality of care in Medicaid health home programs? Are states unable to access the data needed to calculate the measure, or is the data source leading to inconsistencies across health home programs? Is the measure unable to be used to assess improvements in state Medicaid health home programs, or is there another measure that is better aligned with other CMS programs? Of course, this is not a comprehensive list of all reasons for removal, but a few key considerations. Next slide.

That was a lot of information, so I will pause here to take questions from Workgroup members before we transition into voting logistics and practice voting. If you have a question, please raise your hand and I will call on you. Okay. I'm not seeing any questions from the Workgroup. Last call. Okay. Let's move on to voting logistics and the practice votes. Next slide.

I'm now going to provide an overview of the voting process. Next slide.

Voting will take place after Workgroup discussion and public comment on the measure or group of measures being reviewed. Voting is open to Workgroup members only. Federal liaisons and other attendees of today's meeting are not eligible to vote on measures. Workgroup members should let us know through the Q&A function in Webex if they will be absent for a portion of the voting. Each measure will be voted on its currently specified form. If a measure is being considered for addition, a yes vote means “I recommend adding this measure to the Core Set.” If a measure is being considered for removal, a yes vote means “I recommend removing this measure from the Core Set.” Measures will be recommended for removal or addition if two-thirds of eligible Workgroup members vote yes.

Now we're going to move to a couple of practice votes. As a reminder for all 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 Health Home Core Sets Review voting page. If you are not already there, you may use your cell phone and scan the QR code shown on the lower left corner of the next slide to go directly to the voting page. As a reminder, if you are not yet logged in, you will need access to the email address where you received your Core Sets correspondence, as you will receive a code from Slido to access the section where you can cast your vote. It may go to your other folder, so be sure to check there too.

It is suggested that you keep the voting page open for the duration of the meeting, and new voting questions should appear as we make them available. If you don't see the new question, just refresh your page and it should pop up. If you need any help, please refer to Section 1 of the Voting Guide, which we emailed you yesterday, or send us a chat through the Q&A feature in Webex. During voting on measures, if for any reason you are unable to submit your vote, please send us your vote through Q&A or to our email address if you are not able to access Webex. Your votes will be visible to the Mathematica team only. Next slide.

And Talia, there we go, if we can have our Slido come up. There we go. Now for our first practice vote. “Do you prefer dogs over cats?” The option that should appear on your voting page is “Yes, I prefer dogs” or, “No, I prefer cats.”

All right. Thank you, everyone, for your patience while our Workgroup members work through their very first test vote. It looks like we have 14 votes in. If you are a Workgroup member and you are having any questions or problems at all, feel free to reach out to us in that Q&A or email us. Thank you, everyone, for your patience. If you've been here before, you know we get quicker with each time. Looks like we're up to 15. We are waiting on one more Workgroup member to get that vote in. Amy Salazar, if you are able to get your vote in. If you are having any questions or need assistance, please go ahead and ping us in the Q&A or send us an email.

**Patricia Rowan:**

Amy, if you're having any technical difficulties, if you want to raise your hand, we can take you off mute and try to troubleshoot as well. Derek, can we unmute Amy? Go ahead, Amy. Amy, we're not hearing you. You might be muted on your headset or phone. Actually, looks like we got Amy's vote. Amy, are you unmuted? Can you hear us?

**Amy Salazar:**

I can hear you. Can you hear me?

**Patricia Rowan:**

Yes, now we can.

**Amy Salazar:**

Okay, sorry about that. Yeah, I did vote and it registered on my end, so I'm not sure why my vote is still pending.

**Patricia Rowan:**

Okay, I think it did come in on our end, so I think we are good. We have 16 Workgroup members and 16 votes. We're going to do one more practice vote. So Talia, can we go to the next question? I guess we should see the results. Roomful of dog lovers here, which that's where my heart is, too.

Next question, please. The next question is whether you prefer the beach or the mountains. So we'll do another test vote for Workgroup members before we move on to our measure discussion. All right, it looks like we are at 16 votes. Give us one minute just to check on our end and make sure everything came through okay before we move on. All right, I think we have everyone's vote recorded, so let's show the results. Wow, an even split between folks preferring the beach and the mountains. My family just got back from a week in the mountains, and it was lovely, but I live at the beach, so I would be split, too. Let's move on to our next slide and begin our discussion of the measures suggested for addition. So I'll hand it back to Maria.

**Maria Dobinick:**

All right, thank you, Tricia. Amy, I see that your hand is still raised. Do you have another question? Oh, there we go. Perfect. Thank you. Just wanted to make sure everything was okay before we head into it. And now, let's discuss the measure suggested for addition to the 2025 Health Home Core Set. Next slide.

There is one measure suggested for addition that will be reviewed today, Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update, or MLTSS-2. This measures the percentage of Medicaid Managed Long-Term Services and Supports, or MLTSS, participants age 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements. Two performance rates are reported for this measure, 1) Care Plan with Core Elements and 2) Care Plan with Supplemental Elements. Two exclusion rates are also reported. 1) Participant Could Not be Contacted, and 2) Participant Refused Care Planning. The measure steward is the Centers for Medicare & Medicaid Services, and it is not NQF endorsed. The data collection method is case management record review.

The Adult Core Set includes the NCQA version of this measure, Long-Term Services and Supports Comprehensive Care Plan and Update, or CPU-AD. The measure is included in the CMS Home and Community-Based Services, or HCBS, Quality Measure Set, which is also being considered for pilot use in some state 1115 demonstration programs. Next slide.

On this slide, you can see the denominator and numerator definitions for the measure. The Workgroup member who suggested the measure for addition noted that the measure was designed to assess quality of care for members that qualify for managed long-term services and supports, or MLTSS, in Medicaid. However, they indicated that it also has potential to be used for health home programs. The Workgroup member went on to cite that a requirement for health home programs includes care coordination. This

measure identifies the existence of, and timeliness of, a care plan developed to ensure patient-centered, coordinated quality care for members receiving long-term services and supports. The Workgroup member noted a potential barrier is if the state does not require managed care entities to use a case management system, though the measure steward noted that the measure does not require electronic care systems. While the measure does require a review of case management records, these records can be electronic or paper-based.

The measure steward confirmed that the measure does not currently allow for stratification. However, the measure will be undergoing a public comment period in 2023. The upcoming public comment period for this measure will inform updated measure specifications, including potential stratification. Any changes would go into effect in January of 2024 and would be available for the 2025 Health Home Core Set reporting. And with that, I'll hand it back to Tricia, who will facilitate the discussion about the Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update Measure.

**Patricia Rowan:**

Great. Thanks, Maria. Next slide.

All right. So now we would like to invite Workgroup members and federal liaisons to discuss the Medicaid Managed LTSS Comprehensive Care Plan and Update Measure. You can raise your hand in Webex, and we will call on you in the order that we see the hands raised. And you should be able to unmute your line. I see Dee's hand. Derek, can we unmute Dee? Go ahead, Dee.

**Dee Brown:**

Thanks very much. While I appreciate there's a high level of collaboration required between HCBS services and health homes, and there's a requirement not to duplicate care management, these two programs are very differentiated in multiple SPAs and in multiple contract requirements. And there's a lot of variability between states and how they implement it. Whereas in Washington, it's still on the fee-for-service side with state AAA agencies leading the managed long-term services supports, and health homes are incorporated into Medicaid and D-SNP programs now in that market, so there is a high level of collaboration. Whereas in New York, if you think about the New York process, the MLTSS is a separate managed care plan, and the managed care organizations who oversee and monitor the health homes versus the LTSS, there is a high level of collaboration required.

The other thing that's distinct and different between a health home care management approach and the MLTSS approach is MLTSS has to be ordered by a primary care physician in most instances. Health homes do not need to be ordered. A member qualifies and that's it. There's a lot more rigor in a health home program from an expediency, the 120 days that's in this measure versus 90 days in many of the SPAs. And so I do appreciate the fact that there is a high level of collaboration needed, and the states and the plans and the health homes work very hard to ensure that that collaboration occurs. And data exchanges happen to tell us via RAC codes or other pieces of data which members qualify for these services, very similarly with HCBS services as well. I noted that in here the small sample size was noted for in the Medicaid MLTSS plan, and that gets much more de minimis if you cross over who's in an MLTSS versus who's in a health home, because they're not the same levels of participants in those programs. And then the administrative measure is really preferred.

So when you look at the collection of the data from a case management record, which would require chart reviews, is very, very difficult. And again, the small sample size. And states dictate different plans of care between health home programs and LTSS programs. So the plans of care and the different elements in an MLTSS care plan varies greatly from what is required in a state care plan. And the health home thought process that I had was in the long-term services and supports care plan, again, not similar to the health home care plans. And the other aspect is MLTSS is highly clinical. The people that are overseeing those programs include the primary care physician along with nurses to look at complex medical

information. Some of our health home programs aren't highly clinical. Lay people may be overseen by a clinician, but not necessarily. And, you know, community health workers or other care managers that are not highly licensed. So that's also a differentiation between them. And so in my view, they require separate teams within the health care system with separate plans of care that are shared so that everybody is informed of what's in a health home plan of care for the member and what's in the MLTSS plan of care, but they do vary greatly. So those were my comments.

**Patricia Rowan:**

Thank you so much, Dee, for your comments and your sharing your perspective and experience. One thing I would just encourage the Workgroup to think about in discussing this measure is how it could be adapted for health home program reporting, just as we are, you know, whether it would help also to fill the gap in care management and care coordination that has been identified by the Workgroup in previous years as well. Other comments from the Workgroup? Raina. Derek, can we unmute Raina?

**Raina Josberger:**

Hi. Can you hear me?

**Patricia Rowan:**

Yeah, we can.

**Raina Josberger:**

Can you hear me?

**Patricia Rowan:**

Yeah.

**Raina Josberger:**

Okay. Great. I just wanted to echo a lot of the comments that Dee made. I also have many of those same concerns that the care plan for the MLTSS would be very different than the care plan for the health home. And also, you know, the reliability on the health home side, given the small numbers, would be a real concern for me here, just understanding and knowing the small amount of overlap that we have between the health home population and the MLTSS, specifically here in New York. So the numbers are small, and it's just two different types of care planning. And I think that's where this gets a little confusing for me, why we would do something like this, specifically on the health home side.

**Patricia Rowan:**

Thank you, Raina. I want to clarify that if this measure was recommended and adopted for the Health Home Core Set, it would be specified to the health home enrollee population, so not necessarily limited to the overlap of folks who are in both the health home and receiving MLTSS. So similar adaptations were made with the CPU measure as well. So just putting that out there. And Kim Elliott, I see your hand is up. So Derek, can we unmute Kim?

**Kim Elliott:**

Yeah. One of the reasons I like this measure is that it really is focusing on a minimum set of information that would be in the care plan, such as goals for the member, how different functional needs and medical needs and social needs are being addressed and coordinated. There's a lot of steps through that care

plan of the very core basic sorts of things that should hopefully be in most care plans for anyone that is in a program that would require a care plan. It also has supplemental requirements or optional supplemental requirements for a care plan that expand upon that even more and get into a lot of the things that are more for a population that is enrolled in a health home. And those are the reasons I thought this was probably a pretty good measure to consider if it was focused strictly on the health home members.

**Patricia Rowan:**

Thanks so much, Kim. Pam Lester. Derek, can we unmute Pam?

**Pamela Lester:**

Hi. I was excited about this measure when I saw it. In Iowa more specifically, and I think we're unique in that we do have waiver members that are care managed by the health home. So there's that, and I know we're unique in that, and we really should be looking across the board. I would also say that when we look at documentation review, we're looking for core elements because the care plan really truly drives what the health home team should be doing with that member, and it should. If it's comprehensive and really mirrors what's identified in the assessment, we'd want to see those core elements within that care plan. So I really think this is a great measure to look at. And then again, specific for Iowa, of course, it aligns with kind of what we're doing and really helps add robust elements to look at and really work on, especially around goals. Kim mentioned goals, and I've been meeting with NCQA about goals because across LTSS and the health home program, we're not really seeing that deep motivational interviewing to identify truly what their goals are around creating incremental steps to help them reach their goal and truly be patient-centered, and that's what this program is all about. So I'm just really excited about this measure and look to see how it might be adjusted specific for a health home program.

**Patricia Rowan:**

Thanks, Pam. Jeff? Derek, can we unmute Jeff?

**Jeff Schiff:**

I think I got it. Thanks. I had a couple of questions and a comment. There's been this reference to modifying this for health home, and I'm just curious as to what an example of what that would mean potentially. I'm also curious about Dee talked about a small amount of overlap, and do we have any sense of what those numbers are? I know we won't know exactly, but is it 10 percent overlap or is it 50 percent or something? And then my comment is this, that I think that for quality, I think the exclusions are also important because if someone's approached to do care planning and they refuse it, I think that that would tell us something about how well the program is communicating with its participants, because you would think that that number would be relatively small and that some of the exclusions may tell us something about quality as well. So I don't know if anybody has any answers to those questions, but I would appreciate it if there are any.

**Margo Rosenbach:**

Jeff, this is Margo. I can start off with your first point about what it means to adapt to the health home population because, as you know, the Workgroup is intended to vote on measures as they are specified and not modify them for purposes of core set reporting. And we did ask the measure steward, given that this was specified for an MLTSS population, what it would mean to adapt for a health home enrollee population. And it's very similar to the way we would take an NCQA HEDIS measure that's specified for the plan level and change the word member to beneficiary when you're changing it from plan level to state level. So basically, all you're doing is you're changing the unit in the denominator. So I think what we're envisioning -- and I would love to hear from other people, I know Dee and Raina, you've already commented on this as well -- is whether you think that changing the mention from an MLTSS beneficiary,

enrollee, participant, whether that could be adaptable to calling it a health home enrollee. Essentially, you're doing the same calculations and the same measurement, but you're doing it on the health home enrollee population.

And as you and I have talked about fit for purpose, about other measures, I think what we're asking the Workgroup to consider here is whether you could take a measure of care planning that is specified for an MLTSS population and apply it to a health home enrollee population so that you would be getting more into the care planning, care management process, similar to what Kim might have mentioned and Pam Lester might have mentioned. So does that address your question about what it means to say that we would, quote, adapt it from being an MLTSS measure to being a health home measure?

**Jeff Schiff:**

It does. And I think that's a pretty significant potential change, just to comment on what you just said. So thank you.

**Margo Rosenbach:**

A change in the sense that it's more substantive or is it more that you're thinking, kind of thinking about our kind of concepts of desirability, feasibility, viability? I think of that from a desirability point of view, that it might be a measure that's more for an LTSS population, but less so for a health home population because the elements of care planning might apply for LTSS, but not as much for health home. Is that what you mean in terms of it being a major change?

**Jeff Schiff:**

I'm looking at -- as you're talking, Margo, just for myself and other people can do as well, I'm just looking at the core elements to see whether or not they are applicable to health home. I think the change is that you could potentially have a much bigger denominator if you're not just looking at folks who qualify as an MLTSS versus MLTSS services.

**Margo Rosenbach:**

Yes, I would agree with that. Just to clarify, I think the concept that we had in mind when this measure was suggested and when we followed up with the measure steward to determine whether they thought that this measure could be appropriate -- not that it was necessarily, but could be appropriate -- for health home enrollees is that you would be using the health home enrolled population subject to eligibility criteria, the exclusions that you mentioned, for example. Thinking about how the denominator is structured, it would be based on the health home enrolled population. I also did want to respond to your point about the exclusions. We agree this is also part of the CPU measure, the NCQA measure that is part of the Adult Core Set with the exclusions and agree that those exclusions are very important as well for understanding the effectiveness of care planning and the reach of care planning. Presumably those would ultimately be included in the measure as well.

**Jeff Schiff:**

Thanks.

**Patricia Rowan:**

Dee, I saw that you put something in the Q&A and you have your hand raised. Do you want to share your response? Derek, can we unmute Dee?

**Dee Brown:**

Thank you. Yes, thank you. I appreciate the dialogue and Jeff, I think you asked some very pertinent points because it wouldn't be just changing a health home participant or beneficiary. It would be changing the core elements of the care plans, the supplemental elements of the care plans because they are not the same and they're differently defined in multiple different markets. I think the timeframes associated to this measure would require states to go in and modify their health home state plan amendment because most of them have a requirement, --Missouri, New York, Washington -- that there's an outreach at least within the first 90 days and completion of the care plan and in the MLTSS it's 120 days. And when I asked your question, Jeff, about the fit for purpose, when I asked the MLTSS program lead, they said less than 2 percent of their members are in a health home. So just FYI, there's a population that's well served in these programs.

I think where there is synergies and where there might be additional prioritization for future or thought processes around this is how to structure the care plans in both health home and in MLTSS as we move forward to benefit the ability for the collaboration to occur. There are a lot of differences in the two programs, but there's the synergy of the care management. And so you have two care managers doing two different, very different things for members. One, following a primary care physician's prescribed services that they want in the care plan with those elements and a health home program that relies on assessments of the member and the member driving their own care plan for what the individual member needs they feel that they have in a health home program. So I think there are some, and I understand why it was suggested, I think there are some future things that we can think about, about how to create more synergies, because the high level of collaboration is a challenge and then the low sample size is a bigger challenge and the care plan differences is very big. And just the timeframes, everything that's in here is different between the two programs. So that is my thoughts.

**Patricia Rowan:**

Thanks, Dee. We really appreciate that. One thing I will clarify is, as Margo was saying, it is, you know, common in adapting measures for Core Set reporting to align the measure-eligible population as appropriate. But one thing that wouldn't change in the specifications would be the core elements and the supplemental elements. As Maria said, we do vote on measures in their currently specified form. And then as measure stewards provide specifications for state reporting of Core Set measures, they just make those tweaks and adaptations for the population as appropriate. So just want to clarify that. And, Raina, I see you have your hand up. So Derek, can we unmute Raina?

**Raina Josberger:**

So thank you for that comment. I did have a follow-up question on that as well about the process and exactly what we are voting on. So would the vote be at the measure as it's written today, specifically about MLTSS, and then if the measure was adopted for health home, it would come back to be voted on again? I guess that's where I'm looking for clarity, because I was reading it very literally, obviously, and it was specific to the MLTSS. And it sounds like it is not. It's about really the modification to health home. But again, I think that's where, you know, we would have to put our heads together and ensure that this is, you know, approaching this population correctly. And we're not there yet. So I guess that's where I'm looking for clarification on, because I was confused.

**Margo Rosenbach:**

Raina, this is Margo. Those are really good comments. What I would advise the Workgroup when you're voting is to think about voting on this measure as if the denominator is targeted to a health home enrolled population, not an MLTSS population or the overlap between MLTSS and health home. So think about it as the health home population. But to the point that's being made about the applicability of the care planning elements and the timeframes to the extent that those are not aligned or not desirable for

measuring quality of care in a health home program, you are still voting on the applicability of all the other measure elements to a health home population. Just be thinking about how you would apply this measure in your health home population. So your denominator being your health home enrollees. But all the other elements, if you think that the care planning elements don't apply, you think the timeframes don't apply, or other elements, I think those are the things that would not get adapted. Those are the things that are part inherent to the measure. It's really just saying that the denominator wording would be changed instead of MLTSS, it would say health home. Does that help, Raina?

**Raina Josberger:**

Yes, that does help me. Thank you.

**Patricia Rowan:**

Thanks, Margo. Also, if folks are curious, Workgroup members, if you have access to the technical specifications, which are linked in the measure information sheets that we provided, on page 7 is where the specifications for this measure start, and I believe -- or excuse me, on page 7 lists the core and supplemental elements. So folks can take a look at that. Jay Berry, I see you have your hand up. Can we unmute Jay?

**Jay Berry:**

Can you guys hear me okay?

**Patricia Rowan:**

Yeah, we can. Go ahead.

**Jay Berry:**

Great. Yeah, I think the devil is in the details of these nine core elements and 12 supplemental ones, so thanks for sharing the link to the tech specs. So it seems like 21 items needed per patient to adhere with the measure. We've been aware of this measure and just wanted to give you three comments based on some feedback from our pediatric complex care providers. The first is I think that we were hoping that this measure would actually measure more about actions of care planning, and to us it doesn't. It seems like most of the elements focus mostly on documentation of past medical history or functional status, as well as like documentation of active assessments of patient's health. But from a face validity standpoint, like to us the most important aspects of care planning are the actions that are involved in that planning to optimize the patient's health and well-being.

So what are we going to do for the patient in front of us? Are we changing medications? Are we using DME or prescribing new durable medical equipment supplies, diagnostic studies and workup? Are we considering surgeries or diet lifestyle modifications? Do we need team meetings, social family interventions? It's all that action that really is the pinnacle of where all the care planning is trying to go. In our minds, it's the things to do in care planning and tracking the quality of how those things get itemized and how well they get done. For us, this seemed like more of a -- if we were going to go do this, it was going to be more in sort of reorganizing how we're like taking down our basic health history information. And our group felt like the process of going through and doing that to adhere with the measure would take away time from the actual care planning activities that we feel would be the most important.

And the last thing I just wanted to say is from the pediatric perspective, a lot of the supplements and supplemental ones and the screeners that are specified for use were not developed or tested for children. And we would be unable to use most, if not all, of those and would need to find some type of adaptation, major adaptation, to see if there's something existing that could be used for kids or to create something

new, which of course would be its own undertaking. So not to take enthusiasm away from the measure. It's got a lot of great things in it, but just wanted to convey those perceptions from our frontline clinicians.

**Patricia Rowan:**

We appreciate that, Jay. Laura. Derek, can we unmute Laura? Go ahead.

**Laura Vegas:**

I just wanted to –

**Patricia Rowan:**

Oh, looks like Laura got muted again. Okay, Laura, can you hear us?

**Laura Vegas:**

Yes. Can you hear me?

**Patricia Rowan:**

Yes.

**Laura Vegas:**

Great. Thank you. I've had several thoughts come through my mind as people were talking, and then they would kind of answer my question or say the same thing I was thinking. But in terms of, you know, current data collection activities, is there anyone in our Workgroup that could speak to, are health home programs currently collecting data that would get at the same kind of care coordination, care planning quality sort of measure? And if not, I just wonder about the feasibility of adding this measure. Is it possible to collect? I love the idea of having a measure of the effectiveness of care coordination, whether we start with, you know, is the plan appropriate or are the outcomes being met? But I'm just wondering about feasibility.

**Patricia Rowan:**

Thanks for that question, Laura. I saw both Dee and Jeannine put their hands up when you asked that question. Jeannie, did you want to go first?

**Jeannine Wigglesworth:**

Sure. My comment wasn't specifically towards the feasibility, although I could make a little bit of a comment around that. Mine is, you know, within Connecticut, within our health home, we have 14 different providers who all have different EHRs, who all have different programs, you know, outside of health homes that try to coordinate within each other and try to use -- you know, we try to utilize one service plan rather than having multiple service plans. And all those individual programs all have different billing requirements and different specific requirements. So some people build in their service plan into their EHR, so yes, they do have ways of tracking it. Others are, you know, all chart-based. Going through the technical specifications, the areas are very broad. So most of those we are already touching upon, but the language might be different, you know what I mean? And I just, as far as Connecticut, it would be very difficult to get that kind of exact assessment across the board. I don't know how people would, you know, for example, change their assessment in their EHR, I guess.

**Patricia Rowan:**

Thanks, Jeannine. Dee, I know you also raised your hand in response to Laura's question. Can we unmute Dee? Go ahead.

**Dee Brown:**

I did, and I do think it's a really valid question to be curious about. How can we do this data collection, as the last speaker was just talking about in Connecticut, where there's multiple EHRs? That's true in every market. There may or may not be a state collection for health home care plans. In some states there is. In some states they're just starting that work to put the care plan in the state systems. Some of them are prescribed. Some of them talk about elements. This measure specifically has measures that are unique to MLTSS programs and, again, highly, highly clinically driven from licensed clinicians, rather than some of our health home programs that are using layman bachelor's level care managers in a health home program that would not be able to accomplish some of the core elements that are defined here.

So I think it's a really good question. I do also want to say that from a managed care perspective, collecting the data in a single source care management platform that every managed care organization has, coordinating that, collaborating that, and making it available to state regulators to review our oversight of that health home program is also challenging. So making providers who have multiple EHRs or a single system, I would say for those national representatives on calls -- I want to call out Tennessee who did a very great service to everybody in that market where they developed a care plan software element that is available to all of the health homes, all of the providers referring, all of the plans, so that everybody's using a single source for their data and it's available and gives everybody a line of sight into the services that are being delivered in that program.

And I think they likely have -- although I'm not intimate with that program, they likely have a large amount of outcome data, which is to your point of trying to assess what are we achieving by our care planning and what is the outcome that we're looking for. So I would say that the patient activation measure used in the state of Washington measures over time how well a member gets and monitors and feels about their health and their control over their health care delivery. So I think there's lots of different ways to get to that outcome without implementing a measure that was developed specifically for a different program. I don't think it's as easily substitutable, but I think the thought process of having how are we measuring the outcomes in the quality measurements that we are adding or moving or modifying for our core set is a critical core component of what we should be focused on.

**Patricia Rowan:**

Thanks, Dee. Let's go now to Kim. Derek, can we unmute Kim?

**Kim Elliott:**

Hi. So I have the measure specifications pulled up, and I think I've heard a couple of different times that it's very medical-focused and clinician-focused as far as developing care plans, etcetera. So one of the things that the measure specifications does indicate that a care manager is responsible for developing that care plan, and the care manager is not required to have any specific type of professional license. And then when I look at the core elements that must be included in the care plan, it includes things that really one would think you would focus on in a care plan for any type of participant, such as the individualized participant goal. And it could be medical, it could be social, it could be any number of those things.

But what also is important to note for each of those nine core elements is that most, if not all, of them say documentation that the participant is too, let's say, cognitively impaired to provide a goal. That would also qualify for the numerator. Or if the member doesn't have any medical needs, that qualifies for the numerator as met because the questions are being asked and it's being documented in the care plan.

And also there's only one of the core measures that focuses on medical. The rest are focused on community and involvement and who's involved in working with the member or beneficiary on the development of their care plan and whether they have different things in place that one would think most care plans, regardless of program, would include just from a core perspective. But anyway, I just wanted to point that out, that it's not required to be a clinical care plan, and the person developing it does not need to be clinical. There are no license requirements for this particular measure specification.

**Patricia Rowan:**

Thanks, Kim. Jeannie. Derek, can we unmute Jeannie? Let's see. Derek, can you make sure Jeannine is able to unmute?

**Derek Mitchell:**

Patricia, Jeannine should be able to unmute at this point.

**Patricia Rowan:**

Jeannine, you might be muted locally on your phone or headset. While Jeannine is working on that, let's go to Carrie. Derek, can we make sure Carrie is unmuted? Go ahead, Carrie.

**Carrie Amero:**

So I guess a few things to note. I do think -- well, let's see. In fee-for-service, long-term service and supports that are paid for by Medicaid, so like in a home and community-based services program that's fee-for-service, the person-centered planning requirement is really about making sure that the member, the person receiving services, is in charge of their overall plan. And that would include any home health care they need, any personal care they need, as well as transportation, as well as employment counseling and recreation and assistance participating in faith-based activities. And it's really not medical at all. And when you convert that or kind of translate that for managed care, which then is supposed to kind of add the medical piece, I think the idea behind this measure was just to make sure that you don't end up in a situation where you have a medical plan separate from an LTSS plan, which is really human services. It's not medical at all.

What the intention was, I think, is to make sure that there's still one overall plan that addresses a person's medical health needs as well as their quality of life, their kind of human services needs, and that you don't end up with the two things being bifurcated. And so my sense is that that goal and that intention would be a really, I guess, solid parallel to the health home idea, which is that you would be looking at that whole person experience, not trying to have a separate plan for this type of medical service or that type of medical service or this type of mental health. The idea is that you would have one comprehensive plan that the person was very much involved in developing. And I guess that was the other thing I was thinking, is that there has been a concern in MLTSS, and also in fee-for-service LTSS, that the plan ends up just being a written document that doesn't have any meaning and that you can't really guarantee just because of the existence of a plan that the person is really in charge of their services.

But so far, that's like the best evidence that anybody can come up with. I mean, because you can't really audit or monitor, you know, a care planning process that often happens over weeks and with many, many different people. But, you know, the one thing you can do is look at the result in the plan and make sure that it's really comprehensive and that it addresses all the elements. And, you know, doing that, you at least have some sense that, you know, they went through, you know, at least some kind of systematic process to achieve that plan. And so, I mean, my sense is probably the same way here. I mean, it would be great maybe if there was a way down the road to, you know, if there were particular processes that are unique to health homes that, you know, you want to make sure are reflected in the plan that are not in these core measures, maybe that could be added.

But I think the idea is just that the existence of the plan that has all these elements, you know, would have had to have gone through some kind of comprehensive, you know, cohesive process of kind of getting everything that that person needs down in one place. And, you know, like I said, instead of having kind of bifurcated one for medical, one for human services, or even worse, you know, one for every single type of service, which is kind of what you had before CMS implemented the person-centered care planning process. So I don't know. I think there may be more of a parallel for MLTSS specifically as opposed to just fee-for-service LTSS.

**Patricia Rowan:**

Thanks for that, Carrie. Jeannine, it looks like your audio is good.

**Jeannine Wigglesworth:**

Yeah, I'm sorry. I missed the question. I had to step away from my desk, so I missed the question.

**Patricia Rowan:**

Oh, that's okay. We just saw that you had your hand up and wanted to make sure you had the opportunity to speak.

**Jeannine Wigglesworth:**

Oh, I'm sorry. I just never put it back down again from before.

**Patricia Rowan:**

Okay. No problem. No problem. Raina? Derek, can we unmute? There we go. Raina, go ahead.

**Raina Josberger:**

I think I'm unmuted now. So I don't want to reiterate a lot of the points that others have made. I just wanted to point out that when this measure was developed for LTSS, many of the core elements are focused on that long-term care type of population, assessing functional needs, cognitive impairment, which may or may not be appropriate for a health home. So my concern is with just modifying a measure's denominator. The measure was not developed specifically for a health home, and there may be other elements that may be more appropriate for a health home, and that would be my only note here. You know, it's important that a measure is tested and validated in the population it's intended to be used before there's a comfort level, and, you know, there's some data to back that up. So I'm not sure how many care managers of a health home would even be able to speak to the functional need because the person's ADLs were not even assessed. So that's, you know, an area that you'd need additional information before we can expect the care manager to even have a, you know, response to that.

**Patricia Rowan:**

Thanks, Raina. Laura, I saw your hand go up and down a couple of times. Just want to make sure you have the chance to speak if you'd like to share any comments.

**Laura Vegas:**

Yes, I wanted to speak to the service planning experience in HCBS for people with intellectual and developmental disabilities, and we expect one kind of care service plan, person-centered plan -- it goes by many names -- that takes a look at the things that are important to the person, so the things in their life that they want to accomplish that make them happy, that give them a quality of life in the context of the

things that are important for them, so the medical issues and context within where we have to provide our services in order to make sure the person's healthy and safe. So we do have the consolidated type of plan in the IDD world.

**Patricia Rowan:**

Thanks for that perspective, Laura. We are nearing the end of our discussion, so if Workgroup members or federal liaisons have more comments, please raise your hand just so we know how many people are in the queue. Dee, go ahead. Derek, can we make sure Dee can unmute? There we go. Go ahead, Dee.

**Dee Brown:**

Following up on what was just shared about the IDD population, and we are challenged in the health care system with multiple care plans. Let's just really put that out there, that we would like to have one. So to the point that I made earlier to try to assess where there are similarities, yet there are differences. So when we're talking about MLTSS, primary care physician ordered types of services, evaluation for private duty nursing in a home and what level of nursing is needed, doing medication assessment, not necessarily a care manager's level of expertise unless we invested heavily in either clinical oversight of those care managers or training them in those arenas. But I do believe that there is an opportunity for us to figure this out, because talking about IDD populations and the foster care population, which is coming in specifically under the 1945A in health homes, you have a foster care plan for the families in the courts, and we have then a health home care plan.

So how do we look at the variations in care plans and figure out how do we make them more similar than less different? But I do think there are levels of training and required elements that would need to be modified in multiple programs in multiple states. My last statement that I'll make is if you look at the calculations for this measure, it would be almost impossible for a health home program to properly calculate this measure without the assistance of either the state or a managed care organization to look at changing and taking out certain elements of risk acuity and other criteria. It's highly complicated for a health home program that does not have that level of sophistication. So I think that would be another challenge.

**Patricia Rowan:**

Thanks, Dee. And your comment reminded me that I did just want to clarify that this measure would be specified for health home enrollees 18 and older. So that element, the age group, would not change, just as an FYI for folks as we're considering. Raina, did you have another comment, or is your hand up from before? Okay. Oh, go ahead, Raina.

**Raina Josberger:**

Sorry, I'm all set. Sorry.

**Patricia Rowan:**

No problem. Carrie. Derek, can we make sure Carrie's unmuted? Go ahead, Carrie.

**Carrie Amero:**

I feel like just a clarification might be good about who's developing the LTSS plan and for what purpose, too. Managed long-term service supports programs are typically on the hook for people that might need nursing facility care, you know, or home and community-based services, kind of wherever, you know, they can live most independently. And certainly, when you get into nursing home admissions, that requires a clinician to verify, generally, the functional level of care need that's required for nursing. But for all other

LTSS needs, it's usually a social worker or someone with a bachelor's degree. It's not a clinical worker developing an LTSS plan or an HCBS programs that are people service. It's really not clinical at all. I think it's maybe more similar. I mean, certainly there are a lot of people that are getting MLTSS that don't have really any medical needs. It's really just LTSS. But then if they do, you know, then that would be part of whatever, you know, a clinician might order, and it would just kind of be coordinated through that one plan. But most of the things that people get for LTSS do not require any kind of prescription or clinical order.

**Patricia Rowan:**

Thanks for that, Carrie. All right, I am not seeing any other hands raised by Workgroup members. So at this point, we would like to provide an opportunity for public comment. So Erin, can we go to the next slide? Thank you.

So, at this point, if you are a member of the public and would like to make a comment about the MLTSS Comprehensive Care Plan and Update measure, please use the raise your hand feature in the bottom right corner of the participant panel to join the queue. We'll let you know when you have been unmuted, and please be sure to identify yourself at the beginning of your comments with your name and affiliation. All right, and I'm not seeing any members of the public lined up to make a comment. Last call for comments on this measure before we move on to the voting. Okay, great. Thanks, everyone, for such a robust discussion on this measure.

And now it is time for our first vote. So Talia, can you bring the voting platform back up? Great. So our first vote, the question is, “Should the Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update measure be added to the 1945 Health Home Core Set? The options are “Yes, I recommend adding this measure to the Core Set” or “No, I do not recommend adding this measure to the Core Set.” Voting is now open. If the question has not appeared on your voting page and you still have it open from when we were doing our tests, please try refreshing your browser. We are expecting 16 votes. We have received 13. Now I see 14. Workgroup members, if you are having any challenges, please raise your hand. We can try to troubleshoot, or you can submit your vote through the Q&A, and we will enter it for you. We are still waiting on two votes. Be sure you press the send button. We are just going to check to see who we are missing.

Actually, it looks like we're at 16 votes now. Let us just confirm that we have everyone. All right. We have received all 16 votes. So Talia, can you lock the voting and share the results? So for the results, 25 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. So the MLTSS Comprehensive Care Plan and Update measure is not recommended by the Workgroup for addition to the 2025 Health Home Core Set. At this point, we will take just two minutes or so. If any members of the Workgroup want to share, you know, thoughts on why you did not recommend the measure that haven't already been shared, we'll take a couple minutes now to do that before we move on. All right. Seeing no one, can we please go to the next slide? Next slide.

Yes. Thank you all for having such a great discussion, and I also want to applaud everyone for success using the voting platform. This is our new platform this year, so we're glad that everyone was able to connect. At this point, I would like to turn it over to my colleague, Ilse Argueta, to lead the discussion on the first set of measures that were suggested for removal from the 2025 Health Home Core Set. Ilse?

**Ilse Argueta:**

Thank you, Tricia. Next slide.

Now we're going to discuss two measures suggested for removal from the 2025 Health Home Core Set.

The first measure suggested for removal is the Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite, or PQI92-HH. This measures hospitalizations, ambulatory care, sensitive chronic conditions for 1,000 health home enrollee months for enrollees age 18 and older. The measure steward is the Agency for Healthcare Research and Quality, and it is not NQF-endorsed. The data collection method is administrative. The denominator and numerator statements are illustrated on this slide. Next slide.

The numerator statement continues on this slide. Regarding stratification for the purpose of the Health Home Core Set reporting, states should calculate and report the measure for two age groups as applicable and a total rate, ages 18 to 64, age 65 and older, and a total rate for enrollees age 18 and older. However, data may be suppressed for some age groups and performance rates due to small sizes. The measure published by the measure steward can be adjusted for age and sex. It also permits stratification by race and ethnicity.

The Workgroup member who suggested this measure for removal did not suggest a measure to replace it. The Workgroup member who suggested this measure for removal expressed concerns about the technical feasibility of this measure due to states' challenges and limitations accessing the appropriate data source that contains all the data elements necessary to calculate this measure.

This measure has been included in the Health Home Core Set since the initial Health Home Core Set in 2013 and has not been previously discussed for removal. PQI92-HH is not included in the Child or Adult Core Sets, but four components of this composite measure are. In FFY 2020, of the 37 health home programs expected to report on the measure, 25 health home programs reported on the measure. Of the 12 that did not report, seven cited data collection, linkage, or calculation issues. Three reported that there were no measure-eligible enrollees in the health home, and one cited staffing or budget constraints. One did not provide a reason for not reporting. Next slide.

The next measure suggested for removal is the Admission to a Facility from the Community, or AIF-HH. This measures the number of admissions to a facility among health home enrollees age 18 and older residing in the community for at least one month. The three performance rates, short-term stay, medium-term stay, and long-term stay are reported across four age groups: ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older. The number of short-term, medium-term, and long-term admissions is reported per 1,000 enrolling months. Enrolling months reflect the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month. The measure steward is the Centers for Medicare & Medicaid Services, CMS. It is not NQF-endorsed. Next slide.

The data collection method is administrative. The denominator and numerator are detailed on this slide. Regarding stratification for the purpose of the Health Home Core Set reporting, states should report performance rates for the following four age groups as applicable, and a total performance rate: ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older, and a total rate for enrollees age 18 and older. However, data may be suppressed for some age groups and performance rates due to small cell sizes. Additionally, the measure steward reported that the AIF-HH measure, which is the health home adaptation of the MLTSS-6, is not currently stratified. The upcoming public comment period for this measure will inform updated measure specifications for MLTSS-6. Any changes would go into effect in January 2024 and would be available for 2025 core set reporting.

The Workgroup member who suggested this measure for removal did not suggest a measure to replace it. The Workgroup member had concerns about the technical feasibility of this measure due to limitations around data extraction. This includes challenges identifying Medicaid beneficiary transitions of care and admissions to an institution from the community.

This measure has been included in the Health Home Core Set since 2019. In 2019, the measure changed from the measure of nursing facility utilization to the current measure that includes multiple rates and is based on a broader definition of institutional admissions. It has not been previously discussed for removal. AIF-HH is not included in the Child or Adult Core Sets. In FFY 2020, of the 37 health home

programs expected to report on the measure, 22 health home programs reported on the measure. Of the 15 that did not report, four programs reported issues related to data collection, linkage, or calculations. Two cited staff or budgetary constraints. Three cited the length of the continuous enrollment period. Four reported no measure and legible enrollees in the health home program. Two programs did not provide a reason for reporting. Now I'll turn it back to Tricia to facilitate the Workgroup discussion about these two measures suggested for removal.

**Patricia Rowan:**

Thanks, Ilse. So we are going to discuss both of these measures in turn, and let's start with PQI 92. So Erin, could you actually go back to slide 46? Thank you. I thought it might be helpful to have this slide with the information up as we discuss this measure.

So Workgroup members or federal liaisons, if you have comments or thoughts about the suggested removal of the PQI92: Chronic Conditions Composite measure, please raise your hand and we will unmute your line. Jeannine?

**Jeannine Wigglesworth:**

Hi there. We haven't had any issue calculating this measure. However, our end sizes are always really, really small. I mean, even our total calculated number across all 14 providers is incredibly small. And so when we go to try to, you know, compare year over year, we really can't. It's not very usable as far as, you know, percentages going up and down. So that would be my only comment on this measure. It's just that our population for Connecticut is very small.

**Patricia Rowan:**

Thanks for that, Jeannine. Are there other comments on PQI 92? Dee, go ahead.

**Dee Brown:**

I would agree. We don't have a problem calculating the measure itself. I do concur that looking at what is it that we are actually seeing in results doesn't lend itself to a lot of activity for the health home care manager to actually take into account. And I do believe that the fact that we already have the follow-up after inpatient for a member and in our measure period and plan all-cause readmissions I think capture what is trying to be captured here, which is, you know, how many members have been hospitalized and then how many were for a chronic condition and episodes that they had of that service. So we've calculated it, but I don't think it's as actionable. So I appreciate the Workgroup member bringing this up because we have not talked about it in the past, and I think it's worthy of a discussion.

**Patricia Rowan:**

Thanks, Dee. Other thoughts or comments on PQI 92? Amy. Derek, can we make sure Amy Houtrow is unmuted? Go ahead, Amy.

**Amy Houtrow:**

Hi, everyone. This is Amy Houtrow. I really appreciate thinking through this measure. I'd like to try to contextualize it a little bit as we think about other components of the system, because ambulatory sensitive admissions are really something that a lot of hospitals are thinking of right now. And so I'm really posing this back to the group about where do we think a measure like this belongs, and is it in more than one place or is it just in hospital space? I just more am posing it as a question than having an answer to my own question.

**Patricia Rowan:**

Thanks, Amy. David.

**David Basel:**

In reply to that comment, I work with the hospital integrated system quite a bit, and so from a hospital perspective, I agree. We look at these ambulatory sensitive conditions quite a bit on a global basis, and certainly Medicaid being a higher need population falls into this metric quite a bit. So whether we remove this one or not is not going to affect the amount of attention that we pay to these sorts of ambulatory sensitive conditions and would not be a detriment to the health of the population, in my opinion, or the amount of attention that we pay to it.

**Patricia Rowan:**

Thank you, David. Dee.

**Dee Brown:**

I do agree with the last two speakers about that it's a preventive measure for avoidable admissions, that we should try to ensure that the health home care manager is getting members well connected to care that would prevent such a hospitalization. But I also believe that that work is going to continue to look at avoidable admissions, avoidable ED stays. That's an inherent aspect of the health home program, and having this measure saying just for these types of diagnoses are the ones that are the biggest focus, and are we preventing admissions when we are looking at the all-cause admission and readmissions? I think, you know, thinking through those is a good process for the Workgroup to undertake.

I don't know that care managers necessarily connect the dots for the preventive services, and the well connection to all providers in the community is absolutely changing the aspect of what this measure is measuring, and that they're not really connecting this measurement to their work. So I think we would have some education requirements to talk through to help programs understand if there's a variation on this. And like the very first commenter said, there's not a lot of variability in this measure to say, oh, this went up by this amount, and therefore we're doing less preventive care. I think care gap closure is something that health home programs do a really good job at, and I think hospitals are very focused on this work, so I don't know that this is necessarily something we need to keep. I'm not sure.

**Patricia Rowan:**

Thanks, Dee. Jeannine?

**Jeannine Wigglesworth:**

I just wanted to say, in focusing more along the lines of the preventive care, in Connecticut we do our own measure where we're trying to look at preventive screenings or looking at schizophrenic people who take medications that may raise their A1C, and those who are diabetic that are getting their A1C screening. I think there is a measure for it, or they did have the CDC measure out there that's now split up into several different measures. Something like that, I believe, would be more beneficial for us, almost like the COL measure, than this particular measure.

**Patricia Rowan:**

Thanks for that, for sharing. Go ahead, Jeannie. Were you going to say something else?

**Jeannine Wigglesworth:**

No, just, if I were to suggest a measure replacement, it would be one of the diabetic ones.

**Patricia Rowan:**

Okay. Yeah. Are there other comments on the PQI 92 measure? All right. Well, why don't we turn to Workgroup discussion on the AIF measure? So Erin, would you mind going to slide 48?

So now we will discuss the Admission to a Facility from the Community or AIF measure. So if folks have comments on this one, please raise your hand. Raina.

**Raina Josberger:**

Hi. So on the next slide, I think you had mentioned that 22 different health home programs have reported this measure. So I was curious how many of those say they reported according exactly to the specification or they had to use a modified specification. In New York, we had to use a modified specification because the way it was written did not align with the way our Medicaid claims work. So we developed a workaround, which we've been using since 2019. But it's just curious to me how valuable this measure is, if each state has to come up with its own workaround, and how valid that potentially is if the specifications are all a little bit different state by state.

**Patricia Rowan:**

That is a very good question. I am just looking up right now, because I believe that that 22 figure is only- nope, I'm wrong. So for FFY 2020, which is the most recent year for which data is available, 22 programs reported AIF. 18 of them used the Core Set specifications, and four used other specifications and had to deviate in, you know, a meaningful enough way from those specifications. But I don't know, Raina, if you could maybe just say a little bit more about the deviation or workaround that you all used.

**Raina Josberger:**

Yeah. So right, the codes that CMS had given us, we ran initially the first time, and we weren't getting anything. It's because in New York we use rate codes on the fee-for-service side for nursing homes. So you know, they're specific to New York. So of course, we weren't going to pick things up. So when we modified the codes to be what, you know, would be like New York, obviously, then we got rates. And that's what we've been reporting, using other data as well to supplement that so we could understand the length of stay. But, you know, it did take work initially to modify. Now it's obviously written, so it can be run every year. But it was interesting to me to know how many other states had had that initial struggle.

**Patricia Rowan:**

Yeah, thanks for sharing that. Dee, I see that you have your hand up. Go ahead.

**Dee Brown:**

Yeah, I'm having difficulty on this, thinking through if there's going to be a gap left by removing this, why would we do that? And thinking through the difficulty, I think there's a couple of good things about this measure for health home programs in that dual eligible beneficiaries are included in this program, thinking through what that means to a member going in from the community into a stay. I will tell you, there is variability in the health home programs we oversee. I pulled our data. And looking at it, you know, we vary from the short-term stays, 4.45, and I know that you have measures here at the end that you provided, up to 33.62 as the measurements. The medium stays were around the average and some a little bit higher than what you show here.

And then the long-term stays are very, very low for the health home population because we do measure it at a health home level. So I do think having the data is good for us to know. I don't know the variation in programs, whether it's really telling us anything about how many members are getting admitted into a short-term stay, a medium-term stay, or a long-term stay, depending upon the multiple chronic conditions that they have. I don't think a health home care manager really has control over that. So I am wondering if it's not appropriate to remove for that reason. And curious what other people think about this measure, and does it actually leave a gap since we've had it in the program for so long or not.

**Patricia Rowan:**

Thank you, Dee. Amy Houtrow, I see your hand up.

**Amy Houtrow:**

Yeah, thank you. I'd like to talk a little bit more about these issues around the three performance rates because, you know, oftentimes there's an acute event that requires some amount of convalescence or rehabilitation that might warrant a short stay. But it seems to me that unless someone chooses to no longer want to live in the community, there's some concern when there's these long stays about the system not supporting their needs in the community, which if that's the place where people want to reside, then getting those needs met I think are important. I was happy to hear that the rates were pretty low, but it certainly does concern me about thinking about removing a measure like this because of the gap that it would leave. And then the importance of thinking about kind of the legal and ideological goals that we have for people who are high need. We want them to be able to thrive in their communities if they so desire. And so kind of from a big picture perspective, I think this helps us see something. And if we were to lose that, I think it would be a gap that we would have to figure. Not necessarily all of us, but the system would need to figure out how to fill that gap.

**Patricia Rowan:**

Thank you for that comment, Amy. Kim?

**Kim Elliott:**

Yeah, I kind of like this measure. I think that it does have some real benefits and positives for showing the effectiveness or outcomes from the health home program. I really think it's kind of an important one to keep in the measure set.

**Patricia Rowan:**

Thank you, Kim. Jeannie?

**Jeannine Wigglesworth:**

I also find this measure beneficial to be able to look at this level of care. We don't look at it anywhere else.

**Patricia Rowan:**

Thank you. Are there any other Workgroup comments about either AIF -- well, let me see if there are any other comments about AIF before I move on? Jeff.

**Jeff Schiff:**

I just have a question which may have something to do with where this measure came from. But the four age groups I thought were interesting, 18 to 65, and then the three senior age groups. I'm just wondering

if somebody could explain if there's any specific reason. Is it just from where this measure started that it has, you know, the breakdown for seniors into these three categories?

**Margo Rosenbach:**

This is Margo. I can't say for sure. But I think it may have something to do with kind of thinking of it as a descriptive way of risk adjustment, depending upon the profile, the age distribution of the population. We know that it's likely to be higher in the older population, so I suspect that it was a way of kind of controlling in some ways for the age distribution. But if other people have other thoughts, please do jump in.

**Patricia Rowan:**

Dee, I see you have your hand raised. Go ahead.

**Dee Brown:**

I would agree, and one of the reasons why I think the dual-eligible beneficiaries at the age levels is important, as we see more and more Medicare Advantage plans, including health homes, as Medicare and Medicaid align their programs for Medicare Advantage and Medicaid programs. So, I think it's an important thing for us to consider for the aging population that is being managed within the health home services, as well as the adults under 64. So, I do think that that was one of the reasons, thinking of the length of stay for an elderly and frail population, and more and more states are moving in that direction to include that population into their health home program as they become dually eligible.

**Patricia Rowan:**

Thanks for that, Dee. All right. I don't see any other hands raised to discuss AIF. Are there any other Workgroup comments on the PQI 92 measure before we move to public comment? All right. Well, thanks, everyone, for all of your comments on these two measures being considered for removal.

Erin, if we could go to slide 51, we will move into our public comment period. At this point, we will take public comments on either of the two measures suggested for removal that were just presented, the PQI 92 and the AIF measure. So if you are a member of the public and would like to make a comment, please use the raise hand feature in the bottom right of the participant panel. We will unmute your line and let you know you've been unmuted. All right. I am not seeing any hands raised. Last call for public comment on these two measures, and then we will move into voting. All right, next slide, please.

So, at this point, it's time for our next round of voting. The Workgroup will first vote on whether to remove the PQI 92 measure and then move on to the AIF measure. So thank you, Talia, for bringing up the voting.

Our first vote for removal is the Prevention Quality Indicator 92, PQI 92 measure, Chronic Conditions Composite. I know it's a mouthful. The question is, “Should the PQI 92 measure be removed from the 1945 Health Home Core Set?” And the options are “Yes, I recommend removing this measure from the 1945 Health Home Core Set” or “No, I do not recommend removing this measure from the 1945 Health Home Core Set.”

All right. Looks like votes are coming in. We are expecting 16 votes on this measure. If there are Workgroup members having any technical difficulty, please let us know in the Q&A or raise your hand. All right. We have 16 votes. Let us just confirm that we've got everyone recorded. All right. Talia, can you lock the voting and share the results? For the results, 69 percent of Workgroup members voted yes. That does meet the threshold for recommendation. So the Prevention Quality Indicator 92: Chronic Conditions Composite, or PQI 92 measure, is recommended by the Workgroup for removal from the 2025 Health Home Core Set.

Next slide, please, or next question, please.

Our second vote is for removal of the Admission to a Facility from the Community measure, or AIF. The question is, “Should the Admission to a Facility from the Community, AIF-HH measure, be removed from the 1945 Health Home Core Set?” The options are “Yes, I recommend removing this measure from the 1945 Health Home Core Set” or “No, I do not recommend removing this measure from the 1945 Health Home Core Set.” All right. It looks like we have 16 votes. Let us just confirm everyone has been recorded. All right. Talia, can you lock the votes and share the results? Voting is now closed.

So 31 percent of the Workgroup members voted yes. That does not meet the threshold for recommendation. So the Admission to a Facility from the Community measure, AIF-HH, is not recommended by the Workgroup for removal from the 2025 Health Home Core Set. Thank you, Workgroup members.

All right. Can we go to slide 55? All right.

Well, this brings us to the end of our measure discussion today. I want to thank everyone for a robust conversation. We appreciate your contributions, both during our discussion about social drivers of health this morning and in our discussion and voting on measures this afternoon. So now I would like to preview the agenda for tomorrow. Next slide.

Tomorrow we will continue our discussion about opportunities to advance health equity, but this time with a discussion dedicated to the topic of measure stratification. We will also suggest two more measures that were -- or, excuse me, we will also discuss two more measures that were suggested for removal from the 2025 Health Home Core Set. And we will follow the voting on those two measures with a discussion about gaps in the Health Home Core Set. Finally, we will end our review with an opportunity for Workgroup reflections and future directions. And, as always, we'll have several opportunities for public comment throughout the day. We will begin promptly at 11 o'clock Eastern tomorrow morning again, and we ask Workgroup members to sign in a couple of minutes early just to make sure everything is working.

Before we adjourn, I would like to ask our co-chairs, Kim and Jeff, if they have any final remarks to close out today's meeting. So Kim and Jeff. Kim, why don't you go first? I see your hand up. Go ahead.

**Kim Elliott:**

Sure. I think it was an extremely productive day today, and I really want to thank everyone for their very thoughtful participation. I really appreciate that everybody came really prepared for the discussion on the measures with really good, thoughtful rationale for why they thought the measures were good for the health home program or maybe not as good for the health home program. And I really appreciated the discussion that we all had on the differences between LTSS and the health home populations and care management, and also on the feasibility and some of the workarounds that some states are having to do to be able to report some of the measures. So I think that all is really contributing to making some really good decisions and helping everyone on the Workgroup really understand what is and isn't working for some of the states that are on the Workgroup. So I wanted to thank everybody for that. It was very, very helpful, and I'm really looking forward to working with all of you again tomorrow on the next set of measures.

**Patricia Rowan:**

Thanks, Kim. Jeff?

**Jeff Schiff:**

I agree with Kim. I'm looking at this from the perspective of somebody who's been around Medicaid measurement since the beginning, and I want to say that I think the discussions today show a maturing of the process where we look at the gaps not as something that has to be filled with anything that's available, but rather as something to be looked at so we make sure that the measures we put in those slots are thoughtful and meet the desirability, feasibility, and viability criteria. So I think we've come a long way in our discussion. It's a pleasure to see it get to this point, and I think that's reflected in the SDOH conversation earlier. And I'm really looking forward to both the discussion about the removal, but also about the equity and then about gaps that we need to fill. So looking forward to hearing all of you tomorrow. Thanks.

**Patricia Rowan:**

Thanks, Kim and Jeff, we really appreciate you being here. I do want to address -- Amy, I see you had a question in the Q&A about muting and unmuting. So just as folks go into tomorrow, once we have unmuted you for the first time for your introduction in the morning, you should be able to control your mute and unmute buttons. It's only if there is some background noise or if you have to leave the Webex and dial back in that you would need to be unmuted by our team again. So for tomorrow, folks should be able to -- you know, once we call your name for the discussion, you should be able to control your mute button. Thanks for that question, Amy. Sorry, Amy, did you have a response to that? I see your hand raised. Go ahead.

**Amy Houtrow:**

Yeah, this is Amy. I perhaps am the only one, but I have never gained access to control of my mute button today. So even just now, I received the "You can't unmute yourself," and then had to wait until I was unmuted. So perhaps everyone else has the ability to unmute, but I do not.

**Patricia Rowan:**

Okay, thank you. Thanks for letting us know. If you want to dial in a couple of minutes early tomorrow, Amy, we might be able to do some troubleshooting with our technical host. David, did you have a comment? Go ahead.

**David Basel:**

I had the same experience. I get muted every time after I stop speaking and am unable to unmute myself. And that's when I hover over the button that says I cannot unmute myself. So exact same experience.

**Patricia Rowan:**

Okay, good to know. Raina, is that your experience as well? Derek, do we need to unmute Raina?

**Raina Josberger:**

Yeah, I'm having the same issue.

**Patricia Rowan:**

Okay, thank you all for letting us know. We will definitely look at our setup for tomorrow's meeting platform and make sure that if there's a setting that we can change to make sure folks can unmute your own lines, we'll get that changed. All right. Are there any other questions or comments before we adjourn? Okay. Well, I hope everyone has a great rest of your day.

This concludes the first day of the 2025 Health Home Core Set Annual Review, and we look forward to the discussion tomorrow. I hope everyone has a good night. We're adjourned.