

2025 Health Home Core Sets Annual Review:
Meeting to Review Measures for the 2025 Health Home Core Sets Day 2 Transcript
July 12, 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 back to the second 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 review the technical instructions. Next slide.

If you have any technical issues during today's meeting, 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 an audio using computer audio or the Call Me feature in the Webex are the most reliable options. Please note that call-in-only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name in the platform. Next slide.

All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and the public to make comments. To make a comment, please use the Raise Hand feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. You will be unmuted in the order in which your hand was raised. Please remember to lower your hand when you have finished speaking by following the same process you used to raise your hand. To make another comment, please re-raise your hand and the host will unmute you again. Note that the chat is disabled for this meeting, so please use that Q&A feature if you need 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 Tricia Rowan to get us started.

Patricia Rowan:

Great. Thank you, Maria. Next slide. So welcome back, everyone, to Day 2 of our Annual Review, Meeting to Review Measures for the 2025 Health Home Core Sets. I hope everyone had a good afternoon and evening yesterday. We had a very productive first day of our meeting. The Workgroup had a robust discussion on the current state of screening health home enrollees for social drivers of health. In that discussion, there was really broad consensus about the importance of screening for social drivers of health and recognition of the need for a systems approach for referrals and follow-up. The discussion surfaced new insights around the challenges that remain in conducting screenings in a person-centered way and also feasibility concerns with capturing data from providers for program-level reporting. While it seems like there were some promising approaches to screening and referral, there is not yet a viable measure for the health home program.

The Workgroup also discussed one measure for potential addition to the 2025 Health Home Core Set, which was a measure of comprehensive care planning and updates. This measure was developed for the Managed Long-term Services and Supports population. The Workgroup recognized the importance of care planning for health home enrollees but raised concerns with the appropriateness of the measure that was under consideration for the health home population. Ultimately, the Workgroup did not recommend adding this measure to the Health Home Core Set. The first day of our meeting yesterday also wrapped up with the discussion of two different measures that were suggested for removal from the Health Home Core Set. Those were the PQI 92 Chronic Conditions Composite measure and the Admission to a Facility from the Community measure. The discussion of the PQI 92 measure really centered on concerns about small sample size in the health home population as well as concerns about the relevance of the individual indicators that are included in the composite. The Workgroup voted to recommend removing the PQI 92 measure from the 2025 Health Home Core Set.

The discussion of the AIF measure, the Admission to a Facility from the Community measure, really emphasized the importance of keeping health home enrollees out of institutional settings and concerns

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that removing the measure would leave a gap in the Core Set. So the Workgroup did not recommend removing AIF from the Health Home Core Set.

We are looking forward to another day of really great discussion about the Health Home Core Set. But before we begin, I would like to give our co-chairs, Kim Elliott and Jeff Schiff, time for brief welcome remarks. So Kim, I think you went first all day yesterday, so maybe Jeff will ask if you want to go first today.

Jeff Schiff:

Hi, everybody. Welcome back. I think, as I think I said yesterday, these meetings, I think, are really important for the nation and for our Medicaid beneficiaries. I want to say that today I'm especially looking forward to both the discussions about stratification and the discussion about gaps. I kind of want to honor just for a millisecond, or maybe a few seconds, that we have a lot of my pediatric colleagues on this call, and I think that, although there is not a lot of 1945A activity right now, I'm hoping that we use some of the discussion about gaps to talk about where we need to go in taking care of kids who deserve the kind of services that are envisioned under health home initiatives. So thank you very much, and looking forward to today.

Patricia Rowan:

Thanks, Jeff. Kim? Kim, you might need to, there we go.

Kim Elliott:

Yeah, I tried to unmute, but it wouldn't allow me. So thank you for unmuting me, Derek. So yeah, I agree with Jeff. We had a fabulous day yesterday, and I think there was a lot of very robust discussion, which really ultimately leads to the strongest recommendations for either removal or addition from the Core Set. And I also am looking forward to the conversation today, because yesterday the social determinants of health was a really good conversation and showed us really opportunities as well as some of the challenges that we will have going forward with trying to address social determinants of health as part of improving the health care for people enrolled in the health home program. Today's discussion should be equally eventful and filled with information that will hopefully be very useful to us. So I'm looking forward to the discussions today on the measures recommended for removal, but also on the gaps that we need to consider filling and the thoughts and ideas of this committee on where our efforts really should be focused. So thank you, everyone, again, for all of your hard work yesterday and leading up to yesterday and, of course, all the work that will be done today. Thank you.

Patricia Rowan:

Great. Thank you both. Next slide. So now we will do a roll call of Workgroup members just to make sure everybody's here and their sound is working. Next slide. So just like yesterday, we asked that Workgroup members use the raise your hand feature in Webex when your name is called. Unfortunately, we weren't able to completely fix the setting where you can mute and unmute yourself, but we will do our best to unmute you in advance of your name being called so that you should only have to unmute locally. So if you're muted on your phone or your headset or something like that. So after you're done, just please make sure you do mute yourself locally so we prevent background noise and lower your hand. And let's go to the next slide.

So just like yesterday on the next two slides, we have listed Workgroup members in alphabetical order by last name. So as I call your name, please use the raise your hand feature and we will unmute you. We have already heard from Kim and Jeff. So we will start. And Carrie is going to be late joining us today. So why don't we start with David?

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David Basel:

Good morning, David Basel, Population Health Officer for Avera Health. Happy to be back for Day 2.

Patricia Rowan:

Great. Thank you. Dee?

Dee Brown:

Hi. This is Dee Brown. I thought you were going to go to Jay next.

Patricia Rowan:

Yeah, I should have. I missed that. I'm sorry.

Dee Brown:

This is Dee Brown with United. Glad to be here for Day 2.

Patricia Rowan:

Great. Jay, I'm so sorry. I skipped right over you. Go ahead. Derek, we'll need to unmute Jay Berry.

Derek Mitchell:

Apologies. Oh, Jay is at the very top. Thank you.

Jay Berry:

[inaudible] Boston Children's. Thanks.

Patricia Rowan:

Hi, Jay. Thanks for joining. Stacy Carpenter.

Stacey Carpenter:

Hi, this is Stacy Carpenter from Zero to Three, and I'm just looking forward to another robust meeting. I think the conversation yesterday was really great, so I'm looking forward to the same today.

Patricia Rowan:

Great. Macy Daly. Is Macy on the line? If you could raise your hand. There we go. Macy, you should be able to talk. Okay, Macy, can you try again now? You might be muted locally on your phone or headset. Okay, let me go to Amy Houtrow. Amy, are you able to say hello?

Amy Houtrow:

Hi, everyone. This is Amy Houtrow from the University of Pittsburgh. Nice to be back.

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Patricia Rowan:

Great, thanks. Let's try Macy again. Macy, we might have heard a little bit from you. It was a little choppy. Can you try again? Okay, let's come back to Macy, and let's go to the next slide. I see Raina.

Raina Josberger:

Good morning, everyone. Nice to join you again today.

Patricia Rowan:

Great, thanks. Arielle?

Arielle Kane:

Hi, everyone. Nice to be here again.

Patricia Rowan:

Thanks for joining. Pam Lester. Derek, can we unmute Pamela Lester? Go ahead, Pam.

Pamela Lester:

I'm here.

Patricia Rowan:

Great, thank you. Amy Salazar? Go ahead, Amy.

Amy Salazar:

Can you hear me?

Patricia Rowan:

Yes, we can hear you now.

Amy Salazar:

Okay. Hi, everyone. Amy Salazar with the New Mexico Human Services Department. Glad to be here. Thanks.

Patricia Rowan:

Thank you. Sara Toomey? Derek, can we make sure she's there?

Sara Toomey:

I think I'm here now. Sara Toomey, Boston Children's. Great to be here. Thanks.

Patricia Rowan:

Thanks, Sara. Laura Vegas?

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Laura Vegas:

[inaudible] State DD Directors.

Patricia Rowan:

Thanks, Laura. And Jeannine Wigglesworth?

Jeannine Wigglesworth:

I do want to give a disclosure. I have no power today. I do work from home. However, I do have a full battery on my laptop and my phone, so hopefully I'll get power back before I run into any trouble.

Patricia Rowan:

Oh, no. Well, we will be crossing fingers.

Jeannine Wigglesworth:

I know. Hopefully we'll be okay, though.

Patricia Rowan:

Yeah. All right. Let's see if Macy Daly, if we can hear you now.

Mackenzie Daly:

Can you guys hear me at all?

Patricia Rowan:

Yeah, we can.

Mackenzie Daly:

Okay. There we go. Hi, I'm Macy Daly. I am from the Department of Behavioral Health Care, Developmental Disabilities and Hospitals in Rhode Island. It's nice to see everybody again.

Patricia Rowan:

Great. Thanks for sticking with us through the technical difficulty. Next slide.

All right. So just as yesterday, we are also joined today by federal liaisons who are non-voting members of the Workgroup, federal liaisons. If you have questions or contributions during the discussion, please raise your hand and we will unmute you as well. And I would also like to take the opportunity again to thank our colleagues in the Medicaid Benefits and Health Programs Group at the Center for Medicaid and CHIP Services, as well as measure stewards who are attending and available to answer questions about their measures. Next slide.

We wanted to start off today's meeting with a continuation on yesterday's theme of opportunities to advance health equity through the Medicaid Health Home Core Sets. So today, we'd really like to talk about measure stratification, which is another topic that has frequently been mentioned by the Workgroup. Next slide.

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Increasing stratification of Health Home Core Set measures is also a priority area for CMCS. There's really broad agreement that data that is reported at an aggregate program level can mask differences by subpopulations. And if states are able to stratify the data that they report, it can help identify disparities and focus quality improvement initiatives and activities. So before we open up for discussion on this topic, I did want to provide a bit of context on the current options that states have for reporting stratified Core Set data.

So for the FFY 2023 reporting cycle, which will occur later this fall, states will have the option to report Health Home Core Set measures by several stratification categories for each of their programs, health home programs. These categories include race, ethnicity, sex, and/or geography. So I'll go into these categories in a little more detail on the next few slides. For the 2025 reporting cycle, which is the focus of this current review, CMS plans to provide additional guidance to states on stratification categories and definitions. And please note that future categories for stratification may include things like language, disability status, or other topics. However, our goal for today's discussion is really to identify opportunities and considerations for using stratified data to advance health equity and Medicaid health home programs.

Next slide. So this slide presents the stratification categories that will be available for FFY 2023 Health Home Core Set reporting. On this slide, you can see the categories for race, which will include American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, two or more races, or other race. There are also options to add additional race categories that are not predefined in the system, as well as a category for missing or not reported. You can also see that within the Asian and Native Hawaiian or other Pacific Islander categories, states have the option to report stratified data by more detailed categories, if they have that information available that you can see on the slide. Next slide.

States will also have the option to stratify data by ethnicity, which will include non-Hispanic, Latino, Latina, or Spanish origin, Hispanic, Latino, Latina, or Spanish origin. And here, too, states will have the option to add another category or report missing or not reported data. And you can see there's also an option here to report those more granular categories within the Hispanic, Latino, Latina, or Spanish origin category, if states have that information available. Next slide.

Here we have the categories for stratification by sex, which will include male, female, add another sex, or missing, not reported. And next slide.

Finally, these are the categories for stratifying by geography, which will include urban, rural, add another category, or missing, not reported. So again, those are the categories that will be available for state reporting for 2023. Next slide.

Now we'd like, like we did yesterday, to spend some time hearing from Workgroup members on the topic of measure stratification for health home programs. We've included some discussion questions on the slide. So first, how can stratified Health Home Core Set data be used to advance health equity in Medicaid health home programs? How are states currently using or planning to use this data? And how are health home providers and others currently using or planning to use stratified data? We're also interested in the key challenges to collecting, reporting, and using stratified Health Home Core Set data, and what additional resources might be needed to advance this work for state reporting, as well as any other considerations that folks have. Next slide.

At this point, I'd like to open it for Workgroup members to share their perspectives. We'll start with Arielle Kane, followed by Pamela Lester and Raina Josberger, and then open it up for a broader discussion with the Workgroup. So Arielle, you have the floor.

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Arielle Kane:

Hi, everyone. I pulled together some comments, but obviously, based on the discussion yesterday, I feel like I'm not saying things that people don't already know. But that being said, I'm still going to go ahead and dive into it. Data stratification allows for researchers, policymakers, and advocates to collect and review comprehensive race, ethnicity, disability, and other important demographic information, so that we can fully recognize the health needs and health inequities faced by populations and subpopulations across the U.S. And then once we can identify those health needs, we can work on more completely addressing them and coming up with effective and community-focused solutions.

Stratifying Medicaid health home data would help us promote greater equity in the delivery of care by identifying those disparities and helping to allow states to address those gaps in coverage or care. I know that CMS and the Office of Minority Health are really committed to improving how states are able to collect and stratify quality measure data in order to improve the program delivery, reduce costs, and achieve greater health equity. And so, when we're talking about the health homes program specifically, where patients' chronic illnesses are exacerbated by racism, sexism, and other systemic barriers, stratified data would help states improve care delivery and close those disparities. So I wanted to just give a few examples of where we see stratified data and how that can help inform things. So Medicare Advantage does collect and report stratified data, which helps identify disparities in outcomes in care.

And from that, we can see that Black women received worse clinical care than White women for 14 of the 33 measures, the quality performance measures. That is 42 percent, so almost half. And Hispanic women and men received worse clinical care than White women and men on 11 of those 33 measures. Finally, compared with White beneficiaries, American Indian or Alaskan Native beneficiaries reported worse experiences on getting appointments and care quickly. So that is just an example of how, if we were collecting this data in the health homes program, we could identify those gaps and then work on closing them. Right now, it is optional.

And so, some states have built out and implemented specific data stratification strategies. And, for example, Michigan has an annual health disparities report to stratify 13 measures by race or ethnicity. And from this data, the state was able to identify disparities in pregnant women enrolled in Medicaid managed care who received postpartum care. And the data found that Black and Native American women received far less postpartum care than White and Asian Pacific Islander women and allowed the state to develop interventions designed to meet the needs of those populations. In California, states also were able to stratify data and address health inequities through their external quality review program.

And they focused on disparities across race and ethnicity to close those gaps. Sorry, I don't know how long I should talk. So I can keep going. But also, North Carolina also has collected data, stratified data, and that has helped with developing an annual health equity report, which reports on these measures specifically selected to track progress in health equity. So I think that the point I'm trying to make is that states can do this. We have examples of states doing this, and that has led to improvements. And so, I don't think it's a far reach to move towards requiring the Core Set measures to be stratified so that we can close the gaps with these health inequities.

Patricia Rowan:

Thanks so much, Arielle. We really appreciate your comments and the prep work that you did to bring that information to the team. Pamela?

Pamela Lester:

Hello. Arielle did a great job of doing the broad landscape. I appreciate that, and that's really hard to follow. I will talk a little bit about Iowa and some of the things that we are doing around stratification and agree that stratification is really important to be required. As we know, requirements really do drive the

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work that we do. We have a dashboard that will be public that does stratify by race, ethnicity, gender, age, county, to really get a good picture of our landscape. And we also have required the managed care organizations. We have just now three, but in two of them, we have worked on health equity so that we can identify areas around the state and by race, ethnicity, gender, age, to determine where the needs are, where the social determinants of health needs are. And then really target those areas. We have been doing a lot of work in the Black community around pregnant women and implementing the extra doula support for our members while they're pregnant. And that's really began to make a significant impact. And they've also drilled down to specific counties and done specific work there around needs identified of the state. We hope to mirror that and get really good robust data across the state to help support that. And having these required will really help drive that change to be able to look at this subpopulation of Medicaid to really identify if we're seeing these also in the health home members.

Patricia Rowan:

Thanks so much, Pam. Raina.

Raina Josberger:

Great. Thank you both to the prior speakers. Those were both excellent summaries. So just to give you a little bit of background of what New York has done in this space, for our Medicaid managed care program and commercial HMO and PPO, we have been operationalizing a disparity report since about 2016. And we have that data set available open to the public. And really because of New York's diverse population, we found this extremely helpful way to look at quality of care by various demographic characteristics and to potentially identify areas where disparities might exist and to document that quality of care and disparity and potential changes over time.

So there are a number of things that we stratify by sex, age, race, ethnicity, SSI status, some mental health conditions, substance use, Medicaid coverage, and region of the state. For Medicaid, we've operationalized this by pulling those types of stratifiers from our Medicaid data. But for commercial, these limited set of these stratifiers are sent to us each year by the commercial health plans when they submit their annual quality assurance data. So that's how we receive the information and then we aggregate and make that available. How this could potentially be helpful to us for health home, I think the same idea would apply. We have found this very useful for Medicaid, particularly when we start thinking about performance improvement projects. This is absolutely a resource that we go back to and look at each year to ensure that there couldn't be something there that we can make as a performance improvement project for the health plan.

So I think those ideas and principles would apply to health home. The only caution I would have is related to sample size and ensuring that we have enough members in each of the strata to ensure that we have a rate there that we feel comfortable reporting. The other thing I would just flag is just the standardization and how we determine these stratifiers. Race not reported comes in very high for us. You know, it's over 40 percent where we have unknown. So it's very hard to say something about that, so, you know, it's an area where we're continuing to strive to get better data on that. So just flagging some of the concerns we've had in our own personal discussions about this type of exercise. But thank you.

Patricia Rowan:

Thanks, Raina. It's really helpful to hear what you think those concerns might be, you know, for the health home program versus your Medicaid programs more broadly. Let's go to the next slide.

So at this point, we will open it up for other Workgroup members to share their insights and experiences. And next slide, please.

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The next slide will just bring back those discussion topics for your consideration. As folks are kind of, you know, thinking about their comments, if there are other, you know, differences or specific challenges for health home that you have considered, we'd love to hear them as well. So I see Jeannine has her hand raised. Derek, can we unmute Jeannine?

Jeannine Wigglesworth:

I just wanted to piggyback on the last comment is Connecticut also has around a 40 percent unknown rate. And so I am curious and really would love to understand how other states are working on that. I know we have used the, I think it's the BISG statistical calculation, but that really has to be used on a much higher level. You can't use that on lower numbers. So it's really kind of more of a question to the group than a comment. But we are exactly around that same 40 percent of unknown.

Patricia Rowan:

Derek, can we unmute Pam? It looks like Pam might have a response to Jeannine's question.

Pamela Lester:

Hi. We see currently about the same amount as well. Some of the things that our managed care organizations are doing are asking questions in a way that helps support getting that information. One of the other issues we have that we're trying to figure out how to address is we collect this information when they submit their application. And it is an optional. We can't require that question to be answered. And so working with those that help those folks complete that application in language that helps elicit the information to be able to lower that percentage of unknown. So those are some of the things that we're beginning to work on here in Iowa. I don't know if that's helpful.

Jeannine Wigglesworth:

Thanks. It is. Thank you. Thanks.

Patricia Rowan:

Jeff, I see Jeff has his hand raised. Can we unmute Jeff?

Jeff Schiff:

I wanted to piggyback on this issue because I think it's really significant around the 40 percent because I think that's we've heard about that in a lot of states. I think there are a few issues. One is because it's optional, sometimes or very often intake workers don't ask because they don't have to. So I think there's that issue as far as enrollment folks. There's also the need to consider other sources of the data like the data that's at the provider level and electronic records, et cetera. But I think in some ways it would be nice to know where, and I think we've asked sometimes, where do we get the data that allows us to get to a higher level of knowing what the race and ethnicity are? And then the last one, which is not easily done, but along the same line as those records is in Minnesota, we merged birth records with claims records and the birth records were much more accurate. But that's only for a limited population that requires a lot of, I guess I would say data massaging to understand the race and ethnicity on birth records. So I think there are options to do it. I think there almost needs to be some sort of a better workflow so we just don't stop at enrollment data and try to understand the other data. And in some ways, because this is a provider level program at health home, it may be a program where some other methods to collect this data could be tested. Thanks.

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Patricia Rowan:

Thanks, Jeff. Dee Brown, you have your hand raised. Go ahead.

Dee Brown:

Thank you. I'm thinking that maybe these questions are for our national partners that are on the phone, but thinking that there might be an opportunity to put some required data element fields in our claims forms for electronic claim submission for both hospitals and outpatient provider practices so that they would be required to put in one of those options that you had on the very first slide. And then that would apply as well for health homes who are putting in claims for reimbursement as well. So I'm thinking that that's a way to really standardize it as a required element for collection purposes. It would then become much more available to both the states and managed care plans. And they are the folks that are speaking with the members, so they could ask for this information.

And if they put another, they put another. But we would then have some indication if it's a required element on the claims forms. So thinking that's more maybe a CMS question. And from the Office of Minority Health, I was just curious about their thoughts on stratifying this information along with the SDOH data so that we can really start looking at impacted populations that are in a geographic market where there's a food desert or, you know, and they're diabetic. And those kinds of really deep dives that we can use large data sets to be able to assess this. So not looking at the stratification separately from the SDOH discussion that we had yesterday and interested in people's thoughts relative to both those issues.

Patricia Rowan:

Thanks for raising those issues, Dee. If others have thoughts, please do feel free, including our federal liaison partners. If you all have thoughts, please do feel free to raise your hand and we'll get you in the queue to speak. Raina.

Raina Josberger:

Thank you. Yeah, I just want to circle back to Jeff's comment. In New York, we are looking at other data sources, particularly our APD or the All-Payer Database, and comparing that and leveraging the additional information that we may be getting there specifically from claims to help fill in that unknown gap, particularly around this race issue. So we are exploring. And still too soon to share more what we're seeing, but further work is ongoing.

Patricia Rowan:

Thanks for that, Raina. I actually have another follow-up question for you based on your prepared earlier remarks. You mentioned your concern for the health home program would be around sample size and potentially small groups of people. I am just curious, you know, obviously CMS has data suppression rules, but I am curious if New York has, you know, criteria that you use to help decide when you stratify, you know, certain things or not.

Raina Josberger:

We've been using less than 30 as the denominator to suppress for quality measures. So you know, I know there's various standards, but specifically around quality, it's that denominator less than 30, we will not put out.

Patricia Rowan:

Great. Thank you. I see Sara Toomey has her hand up. Can we unmute Sara? Go ahead, Sara.

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Sara Toomey:

Hi. This has been a great discussion. I actually am wondering whether there's an opportunity for states to learn from what hospitals are doing. I think many of us at the hospital level have been giving a lot of thought around collecting this information, and the how is so important. So following up on Jeff's comments about doing this in enrollment, we've tried to shift from where we are doing this face-to-face data collection to where we can get it in other modes. So on portals, et cetera. And we've also done a lot of training of our front desk staff if they are needing to ask these questions. We've even created materials, as have other hospitals I know, to help educate staff, but also patients and families around why this is important.

And so, there might be some opportunities there. We're also doing it, or trying to set up a process by which we're collecting this information at least annually and allowing people to go in and changing it. We know that some of this information does change over time for people, and that it's really important that we're representing who they are as much as possible. And there would be some things that we could share. The other comment, just picking up on Raina's, I think that there is an issue in terms of stratification around small numbers and being able to really comment on whether or not the differences we see are meaningful differences. And so, I do think that's something that the health homes might have to wrestle with at points. And then, I just also wanted to put a plug in, in terms of for pediatrics. Medicaid, and I don't know if this information is available, but Medicaid as a supplemental versus a primary insurance, that could be actually an interesting thing to be looking at from the level of socioeconomic status. In pediatrics, having primary insurance of Medicaid really is a pretty good proxy. But those are just some of the thoughts that I had. Thank you.

Patricia Rowan:

Thanks, Sara. Kim. Kim Elliott. Can we unmute Kim?

Kim Elliott:

Throughout the year, I do quite a few different audits, HEDIS audits, performance measure validation audits, AMP audits of providers in California. And one of the things that we looked at, of course, were the race, ethnicity stratifications that were being completed in each of those different areas. And what we consistently heard from the health plans is they take the enrollment file that they receive from the state and the race and ethnicity data is incomplete. And, of course, that would be the case because it's not a mandatory element when you enroll with Medicaid. What we did find also were the AMP audits, the audits that we do in California for providers. Those tend to be a little bit more complete. They usually don't use the enrollment race, ethnicity data that they receive from the health plans that they work with. Instead, they take it from their EMRs. And they do indicate that that data is more robust, more complete.

So I think there are some really good opportunities to get the information from other sources, as several other committee members have spoken to. The challenge will be where it would be stored for reporting purposes. Enrollment information would always override if it was stored in that part of the system. So there are just things that need to be thought through and different. But there are different ways that the race, ethnicity data could be more complete and more robust for reporting purposes that would really allow some quality improvement efforts to take place based on it.

Patricia Rowan:

Thank you, Kim. David, can we unmute David?

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David Basel:

Thank you. I think I'll pile on and agree with multiple comments that have been made in several different areas. First off, you know, the first thing that came to my mind was, again, the small sample size and the difficulties around that on various stratifications and having to be very aware of that and whether that's going to help for usefulness. In regards to the 40 percent data gap currently in a lot of these data sets, you know, from a rural health system perspective, as we look at our data, you know, we're probably more down around 10 or 20 percent unknown or other in race and ethnicity data. So it certainly sounds like our data is a little bit better than what you have access to today. Realizing that, as was also stated in the clinic setting, that's usually our lowest level employee that's collecting that data at time of registration.

And so validity of that data sometimes is not quite as good as we think it is. And, you know, we've thought about more virtual digital solutions to try to capture that data. But then the people with the biggest challenges of data collection from that standpoint are that population you probably want to get at and, you know, non-English speakers, all of those sorts of challenges. And so it certainly sounds like it may be a step forward that the health systems have a little bit better data than the Medicaid systems do, but they're a long ways from perfect. And there wouldn't be additional data collection burden on providers to get that data because we're already required to collect all of that data, but there would be additional reporting burden.

Patricia Rowan:

Thanks, David. Jeff Schiff, go ahead.

Jeff Schiff:

So I'm really glad we're having this conversation. I want to -- and this may fall into the gaps conversation we're going to have later. But one of the questions I've been wondering about for a while is whether there should be a suggestion to CMS that the source of the race, ethnicity, gender, et cetera, data be collected as well as the data. So there would be a code for data collected at the provider level or maybe even more specifically collected, you know, by, you know, somebody specifically at the provider level. Because I think that what we're really hearing here is that it's really hard to collect it at enrollment and there's reasons not to collect it so that there's no implication that there's racism associated with deciding enrollment. So that's the whole reason why it's not required. But when somebody comes to a provider and they're already enrolled, they have an option to do it. And it would be nice to know whether -- it might be nice to suggest to CMS that they look at how, where and how the data gets collected, as a mechanism to add some opportunities for equity here. I'm curious of what others think about that.

Patricia Rowan:

Yeah, thanks for that question, Jeff. If others have thoughts or comments, please feel free to raise your hand and respond. Arielle, go ahead. Can we unmute Arielle?

Arielle Kane:

I am speaking from obviously not the provider perspective, but I feel like that's a really good point and a good idea because I do know that there's evidence of, for example, providers filling in race and ethnicity data incorrectly, marking people as White who are not White, just to sort of check the box. And, you know, people might also self-identify in different ways. And so I like the idea of noting where the data is collected to inform analysis. And while I do think self-reported data or self-reported race and ethnicity or, you know, gender data is the best, we need to collect it where we can. And that might not always be feasible. So just wanted to build on that and say that I like that idea.

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Patricia Rowan:

Thanks, Arielle. Are there other thoughts or comments from the Workgroup members or our federal liaison partners on this topic? All right. Well, I don't see any other hands raised. So at this point, let's go to the next slide.

We will open it up for public comment. So if folks on the line who are not Workgroup members or federal liaisons would like to make a comment, please use the raise your hand feature, which is in the lower right-hand corner of the participant panel. If you don't see it, you might need to click the little three dots depending on how big your screen is. A hand icon should appear next to your name in the attendee list, and we will call upon you as we see hands raised. And if folks in the public are having any technical difficulties, please feel free to send a note to our team in the Q&A, which you may also have to press the little button with three dots to see the Q&A in the bottom right-hand panel of the Webex. If there are other comments or thoughts from the Workgroup that you would like to share on this topic, please also feel free to raise your hand at this time.

Okay. Well, thank you, everyone, for your participation in this discussion. It's been very helpful for me personally and our team, and we really appreciate everyone's insights and thoughts. Next slide.

So we are just about to take a break. Workgroup members, FYI, that after the break, we will be discussing and voting on measures. So please, as you did so well yesterday, take a minute to log into the Slido polling platform. You will need to open a fresh link and log in the same way that you did yesterday. So you'll use your email address. You'll get an authentication code in your email, and then it should bring it back up. Most likely, if you still have it open from yesterday, it is not going to work. So let us know if you can't find the voting guide that we sent out on Monday morning, but make sure to go back to that original link we sent out and log in anew. If you do have any issues, our team will be around during the break. You can raise your hand and we'll unmute you so we can troubleshoot, or you can put a note in the Q&A. So we will return from our break at 12:40 Eastern Time, so just a little over 45 minutes from now. And I hope everyone has a nice break. Thank you.

BREAK

Patricia Rowan:

All right, everyone. Welcome back. Hope you had a nice break and got some lunch or coffee or whatever will help sustain you through the rest of today's meeting. So at this time, we are ready to move into our review of the final two measures that were suggested for removal from the 2025 Health Home Core Set. So I am going to turn it over to my colleague, Erin Reynolds, to get things started.

Erin Reynolds:

Great. Thanks, Tricia. Next slide, please.

The first measure we'll discuss today is the suggested removal of the Controlling High Blood Pressure, or the CBP-HH measure. CBP measures the percentage of health home enrollees ages 18 to 85 who have had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. The measure steward is the National Committee for Quality Assurance, or NCQA, and the measure is NQF-endorsed. States can use the administrative, hybrid, or electronic health records method to calculate the measure. The denominator and numerator statements are illustrated here on the slide. Regarding stratification, the measure steward, NCQA, began requiring participating health plans to report data stratified by race and ethnicity for this measure for measurement year 2022, which corresponds to the FFY 2023 Health Home Core Set reporting cycle.

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While fields for race and ethnicity must be populated, it is currently acceptable to report a value of unknown. Results are not yet available about the feasibility and completeness of stratified rates. Additional stratifications are being considered for future reporting years. For the purpose of Health Home Core Set reporting, states should report the measure for two age groups, as applicable, and a total rate, ages 18 to 64, ages 65 to 85, and a total rate for health home enrollees ages 18 to 85. However, data may be suppressed for some age groups and performance rates due to small cell sizes. The Workgroup member who suggested this measure for removal did not suggest a measure to replace it.

They also cited limitations on data extraction and the burden of reporting measures that require a medical record review. CBP has been included in the Health Home Core Set since the initial Core Set in 2013. It has not been previously discussed for removal. The measure is also included in the Adult Core Set. In FFY 2020, of the 37 health home programs expected to report on the measure, 14 health home programs reported on the measure. This did not meet the threshold for public reporting of the performance rates for this measure. Of those that reported, one state used other specifications that deviated substantially from Core Set specifications. Of those that did not report, 17 programs reported issues related to data collection, linkage, or calculations. One cited staff or budget constraints. One cited the length of the continuous enrollment period. Two reported no measure-eligible enrollees in the health home program. Two programs did not provide a reason for not reporting. The second measure -- next slide, please.

The second measure we will discuss today is the suggested removal of the Screening for Depression and Follow-Up Plan, or CDF-HH, measure. This measure is the percentage of health home enrollees aged 12 and older screened for depression on the date of the encounter, or 14 days prior to the date of the encounter, using an age-appropriate standardized depression screening tool. And, if positive, a follow-up plan is documented on the date of or up to 2 days after the date of the qualifying encounter. The measure steward is the Centers for Medicare & Medicaid Services, or CMS. It is no longer NQF-endorsed. The data collection method is administrative or electronic health record. Next slide. The denominator and numerator statements are shown here on the slide. For the purpose of Health Home Core Set reporting, states should calculate and report the measure for three age groups as applicable and a total rate -- ages 12 to 17, ages 18 to 64, age 65 and older, and a total rate for health home enrollees aged 12 and older.

However, data may be suppressed for some age groups and performance rates due to small cell sizes. The measure steward has not comprehensively assessed the feasibility of stratifying this measure by race, ethnicity, sex, age, rural-urban status, or disability. The Workgroup member who suggested this measure for removal did not suggest a measure to replace it. They expressed concerns about the feasibility of this measure due to the state's limitations around data extraction needed for the reporting of the measure, specifically the challenges with tracking the follow-up component. CDF has been included in the Health Home Core Set since the initial Core Set in 2013. It is also part of the Child and Adult Core Sets.

In FFY 2020, of the 37 health home programs expected to report on this measure, 13 reported the measure. This did not meet the threshold for public reporting. Of those that reported, three states used other specifications that deviated substantially from Core Set specifications. Of those that did not report, 15 programs reported issues related to data collection, linkage, or calculations. Five cited staff or budget constraints. Two reported no measure-eligible enrollees in the health home program. One program reported that the sample size was too small. And two programs did not provide a reason for not reporting.

This measure was discussed and recommended for removal by the 2022 Health Home Core Set Annual Review Workgroup. Ultimately, CMCS decided to retain the measure in the Health Home Core Set to align with other quality measurement programs in Medicaid and CHIP. CMS recently announced the goal of establishing a Universal Foundation of quality measures that will apply to as many CMS quality rating and value-based care programs as possible. The CDF measure was included in the preliminary list of adult and pediatric Universal Foundation measures. CMS noted, however, that for Medicaid and CHIP, any changes to measure sets will be made in partnership with states and other stakeholders. Now I'll turn it back to Tricia to facilitate the Workgroup discussion about these two measures suggested for removal.

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Patricia Rowan:

Yeah, thanks, Erin. Why don't we go back to slide 23, just so folks have this information right in front of them. We will start with Workgroup discussion of the Controlling High Blood Pressure, or CBP, measure. So if folks have comments or thoughts on this measure, please use the raise your hand feature in Webex, and we will call on you. So at this time, comments from Workgroup members or federal liaisons on this CBP measure. Dee Brown, can we unmute Dee?

Dee Brown:

Hi. I noticed the Workgroup member that put this up for removal cited the limitations on data extraction requiring a medical record review, but NCQA modified this. And they now allow CPT coding for this, CPT-II coding for this. So I just wanted to raise that, and also the fact that blood pressure is a huge chronic condition for members on psychotropic medications, as well as others who are, you know, obese in the program, and diabetic in the program. I just think it's something that we need to think through, because it is an administrative measure. I do want to also say, though, that it is measuring the last blood pressure taken in the reporting period, and that blood pressure must be performed by a clinician, and then have the CPT-II code submitted with the claim. So I'm not sure that every health home program -- and Raina, I'm going to pass the buck over to you, but some of the New York health homes don't have clinicians who are actually managing members in the year. So it would be reliant upon the medical record claims submitted by the providers of service, rather than by the health home. So I want to say that, because New York is the one program I know that some of the health homes do not even have clinicians in their health home area.

Raina Josberger:

Right. Thank you for that. And then we use claims from the health plan. So we're bringing in all that information when we produce this rate.

Patricia Rowan:

Thank you, Raina, for that information, and for Dee, for raising the question. Raina, was there anything else you wanted to add about this measure?

Raina Josberger:

No. Sorry. I just lowered my hand. Thank you.

Patricia Rowan:

Oh, that's okay. Arielle?

Arielle Kane:

Apologies if I'm showing my ignorance here, but the one measure I keep coming back to as we're discussing these is, like, how much it's being utilized. And if only 13 or 14 states are reporting, and they're not collecting enough data in order to make it publicly available, could someone talk about the utility in collecting these measures if they're not going anywhere?

Patricia Rowan:

That's a good question, Arielle, and I'll let other Workgroup members speak to the use of the measure in their programs. I will just mention that the public reporting threshold established by CMS is that 15 health home programs need to report in order for the data to be considered reliable to report, you know, an

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overall performance measure. So I just wanted to clarify that. But if others have thoughts in response to Arielle's comment, please feel free to raise your hand. Jeannine?

Jeannine Wigglesworth:

[inaudible] Health homes that don't deviate from the specifications?

Patricia Rowan:

Yes, that is right. Fifteen programs that report using Core Set specifications. Yep.

Jeannine Wigglesworth:

So in Connecticut, we had to actually create, like, administrative data collection, like, build out in the ASO data information to be able to collect this. Claims does have the ability to start collecting these codes, and the same as when we talk about the depression screens. Once again, these are codes more for -- they're not billable codes, you know, so you can enter them, but we're finding none being entered. So we rely heavily on the system that we built out specifically for our health homes to collect this measure. We do like this measure, though, because we are focused heavily on metabolic syndrome and all those factors that are involved in that. So I would vote to keep it, but as far as the conversation of being able to report out across, I don't think at this point we would be able to report out on it as per spec, I guess.

Patricia Rowan:

Thanks, Jeannine. Jeff Schiff.

Jeff Schiff:

I appreciate the conversation about the reporting difficulty. I wanted to ask -- and I'm not a pediatrician, so this may be not quite my bailiwick, but I'm concerned about the 65 to 85, and especially the 80 to 85-year-olds, and whether or not every clinician would want this to be the goal for every frail elderly patient. So we get into this situation where we put out a measure where the reporting goal, while laudable, across the entire population, kind of misses it. Because even in the 18 to 65, the goal is going to be 130 over 80, and in the 65 to 80 is going to be 140 over 90. And then if you look at some of the literature, which I'm not an expert on and don't practice there, but even 80 to 85, some higher numbers may be acceptable. So we get into this question of whether we're promoting via a measure criteria that are not sensitive to the nuance of treating hypertension. So I don't know if anybody else clinically can speak to this, but I think we have to be careful about that. And I would ask that maybe one of the things we could do is ask for some clarification from the measure steward around that.

Patricia Rowan:

Thank you, Jeff, for the question. I think that there may be someone from NCQA on the phone. If there is, feel free to raise your hand, and we'll be sure, you know, you can speak. Alyssa Hart or Karen Onstad, is this a measure that either of you can speak to, to Jeff's question? Karen. Derek, can we make sure Karen is unmuted? Go ahead, Karen.

Karen Onstad:

I think that this measure -- can everyone hear me?

Patricia Rowan:

Yes, we can.

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Karen Onstad:

Thank you. I believe this measure has an exclusion for frailty. I don't know if there's an exclusion for populations that you were just commenting on.

Patricia Rowan:

Thanks, Karen. I think your audio connection was coming in and out a little bit. I think you said that there may be a frailty exclusion in the specifications. Is that right?

Karen Onstad:

Yes, that's correct.

Patricia Rowan:

Okay. Jeff, does that help answer your question? Go ahead, Jeff.

Jeff Schiff:

Sorry, I muted myself and couldn't get back. It does. I just think that, you know, I think it does on a technical level, but I also worry that that doesn't always get translated well to individual clinicians. So just a point to consider as we think about whether to remove this or not.

Patricia Rowan:

Thank you, Jeff and Karen. Are there other thoughts or comments from the Workgroup on this one? I see Kim Elliott has her hand raised. Derek, can we unmute Kim Elliott?

Kim Elliott:

I do like this measure. I think it's an important one for the Health Home Core Set. But I also do agree that oftentimes it isn't coming through on the claim forms. We see it mostly coming through on supplemental data that's submitted from providers for measure reporting, which states don't always have access to. So I think it is something that will and does have some unique challenges in reporting for the states.

Patricia Rowan:

Thanks, Kim. David? Derek, can we unmute David? There we go.

David Basel:

Yes, thank you. From a health system perspective, we like this measure because of the alignment with other quality programs that we have, particularly Medicare, MSSP. And certainly in our Medicare program, you know, that concern will come up periodically about particularly in the oldest age groups of, you know, you allow them to run a little bit higher. And what we've always told our clinicians is do what's clinically appropriate. There's plenty of 50-year-olds out there that we need to work with getting their blood pressure under control. And if we miss one or two here and there that, you know, are 80-year-olds that we're letting run high, that's fine. And I don't think clinically we feel much pressure to over-control blood pressure. There's lots of folks that we can work on otherwise. And so practically in purpose, at least in reality, we don't feel like there's a big issue from that standpoint. And we're pretty used to dealing with that in the Medicare space.

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Patricia Rowan:

Thanks so much. That's really helpful, David. Kim, I see you still have your hand up. Did you want to make another comment or is that just from before?

Kim Elliott:

I don't see that my hand is raised.

Patricia Rowan:

Oh, sorry. My bad. Other questions or comments from the Workgroup? Okay. Well, why don't we -- can we go to slide 24? Actually, 25. Sorry. No, you were right before. Sorry about that. Okay. Let's continue with our discussion on Screening for Depression and Follow-Up or the CDF measure. I see Jeannine, you have your hand up. Can we unmute Jeannine?

Jeannine Wigglesworth:

Yes. This measure. Oh, boy. So for Connecticut, this measure -- specifically, Connecticut focuses on the SMI population, and we're trying to provide that extra care coordination with the medical providers. So we have 14 behavioral health providers who already do these depression screenings, who already have their own set standards of screening for depression, in many cases that are much higher standards than this as well. And they're not always done on outpatient visits. They're done much differently in all kind of different scenarios. So it's hard for us to use this measure and get any kind of accurate picture of what we really do.

I feel -- and I could be wrong, and please correct me, but I feel like this measure is really geared towards the medical field and making sure that they're doing those depression screenings when people come in and not really necessarily for the behavioral health field who are already doing these. But I could be wrong. But this one we struggle with. We really do. We really barely have to keep to it to be able to get to what we need. We track our depression screens also in a built-out data source as well. And so when we're looking at the denominator here, we're really just looking to see if they had an outpatient but not even connecting that to the depression screen. So it doesn't even make sense for us, for Connecticut in particular.

Patricia Rowan:

Thanks for sharing that perspective, Jeannine. Dee Brown, you're next.

Dee Brown:

Thank you. I remember us voting to remove this measure, and the primary reason was this is depression screening for individuals because under the exclusion criteria, enrollees are not eligible if they've been diagnosed with depression or bipolar disorder previously. So anybody who has been diagnosed already is excluded, and that's the primary reason for people that need to be in a health home is individuals who have bipolar disorder or major depression disorder, and so they're totally excluded out of this measure.

However, I do want to, and so I know that we did say let's get rid of it for a myriad of reasons before CMS overruled that, but I want to offer particularly to CMS two things. One, a state like Washington mandated PHQ-9 measurements on a quarterly basis in their health home program, and so it becomes part of the updated health action plan that they also mandated in that health home program. And so quarterly, the care managers in Washington under the Washington health home do a PHQ-9 screening as a mandatory element of that health home program, and they follow up. So the members are receiving the appropriate care. It's not going to meet this measure criteria, but the care is being delivered. So there is an alternative

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to how a health home can integrate this into their program, and Washington's a good example of that. Secondly, as integrated medical behavioral care under the CoCM model of care in primary care, bringing in behavioral health services, it is annual assessments for both medical and behavioral health are being done in multiple states across the board by the primary care physicians, making sure that they're screening for depression for all new patients.

It's also part of patient-centered medical home requirements. And so there's a lot of other places where this data is getting captured and can be incorporated into a health home program. So I say all of that to say I think because of the exclusions in this measure, I would venture to say it's excluding a large population in the health home just because of the way that the measure is written, and not that the work wouldn't get done or that people wouldn't get screened appropriately because of the expanse of collaboration of care model of care across the board, patient-centered medical homes, as well as mandated health homes who have this criteria built into their programs.

Patricia Rowan:

Thank you for that comment, Dee. Pam Lester.

Pamela Lester:

Hi, I agree with the previous comments. With this, with depression screening, we have templates, assessments, and care plan templates that we use to help ensure that we have a comprehensive assessment and then a plan that's reflective of the needs in the assessment. And we have the PHQ-2 built into that. So all members are asked these two questions, and it does not get captured because it doesn't meet the visit type. And, of course, the claim doesn't identify that that screening was completed. And then, of course, they are to follow up with a referral if that's positive, or some of them automatically have the PHQ-9 built into their electronic health record. So the PHQ-2 is really not necessary for those health homes. So those things are in place. They're being done. We do file reviews to ensure that that was done and that there was follow-up if we saw a positive screening. And then the depression, when we look at that specific measure, as Dee had said, excludes them, which is a huge part of our population in both the chronic condition or the primary care and the behavioral health state plan amendments that we have.

Patricia Rowan:

Thanks, Pam, for sharing your experience there. Other comments from the Workgroup or federal liaisons on this CDF measure? Peggy O'Brien. Can we unmute Peggy? Go ahead, Peggy. We should be able to hear you now.

Peggy O'Brien:

Yes, Peggy O'Brien from SAMHSA. I just wanted to comment that this measure is also among the required measures for the CCBHCs, and the blood pressure measure is going to be among the optional measures for the CCBHCs reported by the CCBHCs at the clinic level, just for information purposes. That's all.

Patricia Rowan:

Peggy, just for the record and for folks who may not be as familiar, can you just define what you mean by CCBHC?

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Peggy O'Brien:

Sure, happy to. The CCBHCs are the Certified Community Behavioral Health Clinics. They started as part of a Medicaid demonstration and have grown and will continue to grow. There are presently both demonstration clinics and clinics that are CCBHCs through part of a discretionary grant program that also will be required to report this. There are probably a total of about 500 around the country at this point, and there is probably a fair amount of overlap with some health homes. Thank you. That was going to be my next question for you about the overlap with health home programs, so thank you. Neeraj, I see we have Neeraj from HRSA.

Neeraj Deshpande:

So just a comment, so as part of its health center program, we do collect data on Screening for Depression and Follow-Up as well as blood pressure measurement, and that's part of our UDS reporting for BPHC in HRSA.

Patricia Rowan:

Great, thank you. Are there other comments or questions from the Workgroup on either the CBP or the CDF measure before we move into public comment? Okay. I am not seeing any other hands raised, so now let's go to slide 27.

At this point, we would like to provide an opportunity for public comment. If you have a public comment about the Controlling High Blood Pressure, CBP measure or the Screening for Depression and Follow-Up Plan measure, the CDF measure, please use the raise hand feature in the bottom right panel of the participant panel to join the queue, and we will make sure you are unmuted. I am not seeing any members of the public lined up to make a comment. If you would like to make a public comment, please use the raise hand feature in the bottom right corner of the participant panel, and we will unmute you. If you are having any trouble, please let us know in the Q&A.

Okay. I am not seeing any members of the public wanting to make a comment. I would like to, since we have a bit of time, go back to Workgroup members and see if there are any other comments on these measures. I know we heard some concerns around feasibility of the measures, especially if these measures are subject to mandatory reporting. We also heard from our federal colleagues about alignment with other programs, and so I just want to open that up to the Workgroup to see if anyone has any other thoughts on these measures before we move into voting.

Okay. Well, maybe folks have said their piece on these two, so why don't we move on to the next slide, and we will move into our next round of voting.

So please note again that only members of the Workgroup are eligible to vote on measures. The Workgroup will first vote on whether to remove the Controlling High Blood Pressure measure, and then the second vote will be on whether to remove the Screening for Depression and Follow-Up Plan measure. So Talia, can we bring up the voting platform? Thank you.

The first vote of the day is, "Should the Controlling High Blood Pressure, CBP-HH measure, be removed from the 2025 Health Home Core Set?" The options are "Yes, I recommend removing this measure from the 2025 Health Home Core Set." Or "No, I do not recommend removing this measure from the 2025 Health Home Core Set." Today, we are expecting 15 votes. If folks are having any trouble with the voting, either raise your hand and we can help you troubleshoot, or feel free to put your vote in the Q&A for our team, and we can record it on your behalf.

Okay, looks like we have 15 votes. Our team is just going to confirm everything was recorded, and then we will share the results. Give us one moment, please. All right. Can we close the voting and share the

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results? So for the results, 40 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. So the Controlling High Blood Pressure, CBP-HH measure is not recommended by the Workgroup for removal from the 2025 Health Home Core Set. Next measure for a vote, please.

Our second vote today is, "Should the Screening for Depression and Follow-Up Plan measure, CDF-HH, be removed from the 1945 Health Home Core Set?" The options are "es, I recommend removing this measure from the 2025 Health Home Core Set." Or "No, I do not recommend removing this measure from the 2025 1945 Health Home Core Set." If you do not see the question on your screen, try refreshing. Okay, we have 15 votes. We will double-check and announce the results. One moment, please.

All right. Can we lock the voting and share the results? For the results, 67 percent of Workgroup members voted yes. That does meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan measure is recommended by the Workgroup for removal from the 2025 Health Home Core Set.

So that brings us to the end of our measure discussion and voting. Thank you, Workgroup members, for a productive conversation and for sticking with us on voting for the measures that were being considered. Now, I am going to turn it to my colleague, Maria, to help us start a discussion around gaps in the Health Home Core Set and prioritization of those gaps. Maria?

Maria Dobinick:

Thanks, Tricia. Can we advance to slide 31, please? Great.

Now, we're going to transition to a discussion of gaps in the Health Home Core Sets. We would like the Workgroup to suggest priority measures or measure concepts for future Health Home Core Sets and also priorities for measure development, testing, or refinement. Next slide.

I'd like to begin with a brief recap of the gaps in the Health Home Core Set that were identified and discussed during the 2023 Annual Review. As you know, the annual Workgroup process is designed to identify gaps in the existing Core Sets and suggest updates to strengthen or improve them. It is important to note that the gaps discussion did not prioritize the measure gaps suggested by individual Workgroup members, assess the fit or feasibility for the Core Sets or represent a consensus about the gaps. In some cases, measures may not be available to fill a potential gap, resulting in suggestions for additional measure development or refinement. Nevertheless, this information may be helpful as a starting point for considering updates to strengthen the Health Home Core Sets, as well as longer-term planning for future Core Sets. Next slide.

This slide illustrates the measure-specific gaps discussed by the 2023 Workgroup. As discussed yesterday, one of the gaps is the lack of a measure of social drivers of health, such as housing status or food insecurity and referral and follow-up from that screening. Other gap areas raised last year include hepatitis C screening, primary and preventive care, including adults, access to care, annual well visits, weight management, and health promotion, HIV care, maternal and child health, including prenatal and postpartum care, and experience of care and satisfaction with care. Next slide.

The synthesis of the 2023 gaps discussion continues on this slide and highlights some measure concepts related to care delivery that include the integration and coordination of behavioral, mental, and physical health services, care coordination, including whether health homes are successfully coordinating care and whether health home enrollees know how to reach their teams for care coordination, and beneficiaries' ease of using health home care systems, their ability to move throughout the system, and their ability to get timely needed care.

The Workgroup also discussed cross-cutting methodological considerations, including this morning's exploration around opportunities to stratify measures by race, ethnicity, language, geography, and other

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factors to identify disparities. The 2023 Workgroup also noted a desire to explore the use of existing data sources to realize efficiencies in reporting and to reduce state burden, for example, using data from the Transformed Medicaid Statistical Information System, or T-MSIS, and a consideration of challenges related to sharing information with health home care managers if the information is sensitive or protected, for example, information on alcohol and other drug treatment or HIV viral load suppression. Next slide.

Now we'd like to hear from the Workgroup on their thoughts regarding gaps in the Health Home Core Sets. Here are some questions for the Workgroup to consider. I'm going to read through them and then open up the discussion. First, thinking about all the gaps previously identified by the Workgroup, what are the priorities for future Health Home Core Sets, and are there existing measures to fill the gaps? Next, are there other high-priority gaps not previously identified? And finally, what gaps should be prioritized for future measure development, testing, and refinement? And with that, I'll hand it back over to Tricia to facilitate this discussion.

Patricia Rowan:

Thanks, Maria. So if folks have comments or thoughts from the Workgroup or federal liaisons on the topics here on the slide or gaps, please raise your hand and we'll start the discussion. Dee Brown. Derek, can we unmute Dee?

Dee Brown:

Thank you. I think we had a very robust discussion about the SDOH-1 quality measure and the problems that we saw with several areas, including the last measure that we talked about with consents to be able to share substance abuse data similarly in this measure, and that it's not been tested yet. That's something that we need the Medicaid and programs to see if we could test this measure in a market so that it could become technically something that we could consider. And I think all of that robust discussion showed that we weren't ready to use this yet because we haven't tested it out. There's a lot of variability here. What we needed to see was some testing of this, so I would recommend that we do that.

But then also, I would really love to hear some dialogue about being able to ensure that the states are collecting member consent to share their clinical information when we have health homes. And I'm speaking from a managed care organization, so other people can give other opinions. But if a health home has to specify which managed care organization they're going to share their data with, the health homes want to have a blanket capability to have us do that. But it's a HIPAA violation for us to do that without the member consent being on file in our medical record. And then then the barrier becomes, okay, if you have 10,000 members in a health home, then that's 10,000 consents that need to get stored. So the interoperability of keeping member release of data information to comply with HIPAA is a huge barrier to us being able to share actionable data to the individual health homes. And I know that states have taken some sense of direction in this manner to be able to either, A, capture that data in their state systems. But that doesn't address the fact that the regulations require that it's in our medical record.

So that's just a problem in how some state regulations are done. And I think we just need to figure out a way because we haven't figured it out at UnitedHealthcare. That's a big organization with lots of attorneys and they just can't get there. So I'm very reticent in feeling like I want to empower the care managers to have all the data they need, and we're not able to do that. So I think the social drivers of health, if we could test that data, maybe over the next year with the robust discussion that we had yesterday and then also look at this consent issue. And then we all know -- my final statement. We all know that following -- and we've got a lot of pediatricians on this call. I know that following the pandemic, we are missing children and their wellness vaccination records and getting them vaccinated. And I know some of that was associated to the autism fallacy of connection. But I don't know what we can do about figuring out how to get those measures back up. They failed over the last two years to be as robust as they used to be. And just interested in others' thoughts on well-child visits and adding that to our measure set.

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Patricia Rowan:

Thank you for that comment, Dee. Amy Houtrow. Can we unmute Amy?

Amy Houtrow:

I appreciate the opportunity to say something that I think many people certainly feel and I felt that really resonated and hit home with me over these last couple of days. As a pediatrician, I'm very desperate to want to talk about well-child care and also the issues around vaccinations. But I didn't want to miss the opportunity to kind of drill down and like the big picture. What has really hit home for me is how we're talking about programs that have different purposes and who serve different people and how the people involved who are running them are educated in certain ways or have certain certifications or not. And then how the data is available and shared, how all of those things make it really challenging. And I'm wondering if this is a space and perhaps it's not where we have discussions about harmonization, because I think until that occurs, many of these measures are just not going to make so much sense and they won't be -- we talked a lot about feasibility and so much about how we could not get data that we needed. It seems like some bigger picture harmonization really needs to happen.

And when I think about gaps, the kind of high-priority gap for me is that not in a specific quality measure area, but kind of across the board how we get to the place where the quality measures are meaningful and also achievable. And so perhaps I'm thinking too pie-in-the-sky, but I just wanted to take the opportunity to kind of tell you all what hit home with me over these last couple of days. And most certainly we have a huge problem on our hands with the massive lack of trust in health care, including trust in pediatricians who used to experience very high levels of trust. And I think as we talked about the issue around equity, there's so many opportunities for us to do better, to take care, make sure people get what they need. And so I really want us to attend to the issues around quality measures, but I'm very challenged to think about how we get over these kind of big, big hurdles in an effective, meaningful way.

Patricia Rowan:

Thanks so much for that, Amy. When you talk about harmonization in health homes and other programs, are there specific examples that you would like to see addressed?

Amy Houtrow:

Sorry, I needed to be re-unmuted. I had muted myself. And, yeah, I just was thinking about like listening to the different folks from various states talk about their how their different programs operate and who they serve and who manages them and what is feasible and what's not. And I don't know if it's minimum standards or anything like that that would really help get us to the place where -- our feasibility conversations, they have seemed to be that we can say things like, we know states can do this. X, Y, Z state does this. And then other states say, you know, this is not an appropriate metric for us because of X, Y and Z, or we can't measure it because of X, Y and Z. So I don't have great specific examples to give you. But that's my gestalt from the way we've been talking over the last couple of days. And then also how over the course of my service on this Workgroup have felt that we are really grappling with these when we think about, you know, of the kind of overlapping Venn diagram of what makes a good measure, where we're going to continue to find challenges to a good measure because there is this lack of harmonization.

Patricia Rowan:

Thank you, Amy. I think one of the reasons we appreciate this Workgroup so much is because you help us identify those important areas to think about. One thing I did want to mention in response to Amy and Dee's comment, as it relates to well-child visits and immunizations, is that if you look at the measure list for 1945A health home programs, and again, these are the new state option for health home programs that will care for children with medically complex conditions. Of the seven measures that are on that list,

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there are two well-visit measures. There's a well-child visit in the first 30 months of life measure, as well as a child and adolescent well-care visit measure. There is also a child immunization status and an immunization for adolescent status measure. So I just wanted to make sure folks were aware of that, and we can share a link to that measure list in the chat just momentarily. So thanks. Jeff Schiff.

Jeff Schiff:

Thanks for this discussion. I wanted to, if I could, just talk for a minute about fit for purpose and then get into some specific gaps, because I really think, you know, I have the pleasure of both working with the Medicaid folks and also working over at HRSA with the MCHB folks. And there they think about measures around quality of life, around the specific populations being served, like children with special health care needs, and then who the accountable entity is. And I think here at Medicaid, we think about, as we talked about yesterday, the accountable entity for the child and adult sets are the states, and the accountable entity here is really the provider or the program doing the health home. So I think that to get then from sort of that macro look down to thinking about what we need to consider as gaps in health home, you know, there are those six core services in health home.

And in some ways, we measure around those services, and we haven't measured directly about whether care coordination is happening or whether or not there's care integration or whether addressing folks' social needs. And I think that that's both something that we want to wade into carefully as we think about how to close that gap, but also something that we can't not wade into. So I'm saying this because I know that in the Core Set conversation, there was a pretty long conversation about whether CAHPS should be there or not, and not lost on me at least, and many of us, is that there's not CAHPS here, where CAHPS really may look at whether or not certain care coordination functions actually are occurring. So I think we have to look at how we measure the patient and the family care coordination. And I'm not advocating for CAHPS necessarily because it's got problems, both because of how it's been structured, but also I think we have to think about how we get to measures of care coordination, including probably family and patient surveys, but maybe in a different way that's perhaps more achievable.

And then just one other comment about for the 1945A is I think that, you know, we look at well-child visits, but we need to get under the hood at some point and look at what's included in the well-child visit. There's a developmental screening measure that's been problematic, I know, in the Core Set, but still there. And I think we have to think about what we want to screen folks for, and that kind of ties back to social determinants and how we do that. But I think there are things like resiliency and adverse childhood experiences and social-emotional screening, as well as developmental screening, that we have to at least put on the plate as needs for this group to consider in the future. Thank you.

Patricia Rowan:

Thank you, Jeff. Amy Houtrow, I see your hand is up. I can't remember if that's from earlier or not. Okay. Looks like it's down. Kim Elliott. Kim, if you wanted to make a comment, maybe just raise your hand again and we'll - there we go. You got it. Yeah.

Kim Elliott:

I think I really like what Jeff said, and I do agree with a lot of what Jeff just said. I think one of the big gap areas still is the care plan and how we're coordinating the care for the members that are enrolled in the health home programs. So I think that is an area and a gap that I think really needs to be a little bit of a focus. And, you know, the measure we reviewed today, or yesterday, I guess it was, I like that measure, but if we could find one that has similar components that really address the health home, that would be something I think would be really valuable for this core measure set.

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Patricia Rowan:

Great. Thank you, Kim. Jeannine Wigglesworth. Can we unmute Jeannine?

Jeannine Wigglesworth:

Hi there. I just have a quick question. I was wondering if anyone else would find it beneficial to maybe have continued conversations in subgroups? So I would love to continue conversations with other states who are working, focused on the SMI population with care coordination with medical providers. Just narrowing, I think, you know, so it's not just kind of Connecticut's experience with our Medicaid system, with, you know, our population, but maybe coming across, you know, with other experiences, we might be able to generalize some of these gaps even a little bit more. I don't know if other people would find that beneficial. And then my other comment is I know the adult core, CMS adult core, are focusing two measures on diabetes coming up, and we for the health home are actually going to pick up those two because we were doing kind of like a homegrown measure around diabetes. So we are going to pick up those two. One of them is the SSD, and the other one is the HPCMI. So one of them is looking at diabetes care for those with serious mental illness, and the other one is looking at those who are taking an antipsychotic and looking for the A1C. So it kind of helps us look a little bit ahead of the more preventative around diabetes, which is a huge factor in our population.

Patricia Rowan:

Thank you for that, Jeannine. I really like your idea for a separate group, maybe as a quality improvement type of opportunity or something like that. Dee Brown.

Dee Brown:

Thanks. I just want to echo the last three folks, Jeff and Kim, and thinking through, I like the diabetic measures that were just offered up. I think that's a great idea. But I wanted to just offer that there is -- and I think I spoke about this the last time, last year, but in Washington, and CMS just adopted this tool, it's not a measure, but it's the patient activation measure, Jeff, and the caregiver activation measure, the PAM and the CAM, that are -- it's a proprietary tool, and it costs money. So that's the key problem with it. But it gets to what you were talking about, Jeff, where we're actually looking at the outcomes, that how does the member feel, how does the caregiver feel, relative to the member's care coordination services that they're receiving. And it really shows when a member becomes involved in managing their own health, which would be the goal in anybody, that not the care manager isn't managing the health, but the member themselves becomes capable or their caregiver becomes capable of managing their care.

So I just want to offer that up. I tried to use it in another program in another state, and it just is costly and prohibitive. But if CMS could figure out a way, make it available to providers more generally, because it is a proprietary tool, it is a great tool to really figure out how a member is doing over time, how are they actually in. And it's not a survey, which people will ignore. It's a care manager requirement. So I think it's a value add. I just don't know how to get over the cost gap with this tool. But it would give us a measure set that we could be very reliable on. So interested in CMS's thoughts since they have now given their stamp of approval to this tool.

Patricia Rowan:

Thank you, Dee. Jeannine. I see your hand is up next.

Jeannine Wigglesworth:

I'm sorry. I forgot to lower it.

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Patricia Rowan:

Oh, that's okay. That's okay. Pam Lester.

Pamela Lester:

Hi. I agree with Dee. I think that would be really great. I feel like many times our members are surveyed out between our surveys for LTSS and the CAHPS surveys for the managed care organizations. The thing, and this is kind of really out of the box, and it might be way too far out there, but it might start a discussion that gets us maybe somewhere that really helps drive this program in outcomes, as previously talked. But is there the ability to take -- you know, we talked about social determinants of health yesterday, and we talked about the LTSS, you know, core and additional elements. Is there a way to create a health home measure that identifies that the social determinants of health were addressed in the care plan along with goals, because that's something that we see that increases engagement, and just different elements in a care plan that would really help drive improved outcomes. So I didn't know if there was any potential around considering that or something similar to that.

Patricia Rowan:

Thanks, Pam. That's really helpful, because as there is on the slide here, we're also really interested in folks' thoughts on priority areas for measure development and measure refinement. And we have representatives of different measure stewards on the line, so we appreciate your comments. Jeff Schiff.

Jeff Schiff:

Thanks. This is a great discussion. I just wanted to respond to Dee and maybe to Pam as well. I think one of the questions we ought to think about as we prioritize what we want to know is whether we want to ask people, if we're going to think about what we may want to ask people, you know, we may want to ask them first about whether they have access to care, and then whether or not the services like having a care plan or like having their social determinants of health are addressed. And I would say that may be enough. At least I would prioritize that maybe over, did they feel like they were empowered? I'm not saying that folks feeling empowered is not important. I just think that it's more subjective and a little bit harder to test. So I'm kind of, you know, in the same way you go to quality of life measures. It's like we would like everybody who has a health home to have an improved quality of life, but there are a lot of factors into that that are not accountable to the health home entity. So I guess what I'm saying is maybe as we go along and talk about prioritizing, we should think about whether we want to prioritize access and actually what happens in the care setting, and then ask about how people feel about their setting, and whether their quality improves. And I think about that as a continuum. So it may be helpful to think in those terms as we think about how to prioritize meeting the goals of the health home program.

Patricia Rowan:

Thanks, Jeff. Pam Lester. I don't know if your hand is still up from before or if there's another comment you'd like.

Pamela Lester:

It was still up. I apologize.

Patricia Rowan:

That's okay. Dee Brown.

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Dee Brown:

Thanks, Jeff, for your comments. And I'm thinking about AHRQ took this on to look at care management effectiveness back in 2008. And it just never has been developed into a core measure set. So I would ask the national representatives on the call if they could consider or tell us if there's any movement on what AHRQ published back in 2008 about care management effectiveness and if there are any measures right now that we could consider as a Workgroup for use in health homes.

Patricia Rowan:

Thanks for that question, Dee. If there are representatives or measure stewards who want to speak to that, feel free to raise your hand. But for now, let's go to Sara Toomey. Can we make sure Sara is unmuted? Go ahead, Sara.

Sara Toomey:

Hi. So it's been an interesting conversation. I guess I'm just going to reiterate the need to think about how we can screen for health-related social needs in this patient population, because I think that is going to be really important moving forward. But the other thing I want to put a plug in for that Jeff alluded to in part two is care coordination. I do think that that remains a gap. It's very difficult, admittedly, to measure. But when we think about what the goals of having these home health programs, I think that that really is something important for us and will be also important for us to be looking at through the disparities lens. Thank you.

Patricia Rowan:

Thanks, Sara. Are there other thoughts or comments from the Workgroup or federal liaisons on this topic of gaps? While folks are thinking, one thing I'd like to do to kind of close out this conversation and just see if, you know, where the Workgroup is on this topic is we are going to do a quick rundown of the roster for Workgroup members and ask folks to identify your highest priority gap or highest priority area for measure development or refinement as it relates to health home programs that can help us prioritize. So start giving that some thought, and as the comments slow down, we'll shift into that exercise. Okay. Well, I am not seeing any other hands raised on this topic. So I am going to ask folks, like I said, to call on you in the same order we did the roll call and just ask folks to kind of share what you think the highest priority should be. So Kim, I'm going to start with you, if that's okay. Kim Elliott.

Kim Elliott:

Thank you. There are a lot of priorities that I can think about. I really do think that the care planning and how we're really working with the individuals and working within that patient-centered approach is really an important thing to include from a core measure perspective. So that would be my highest priority right now.

Patricia Rowan:

Thanks, Kim. Jeff Schiff. And if folks can't just prioritize one, it's okay to name one or two. We're just trying to see if there's consensus around some priority areas here. So Jeff Schiff.

Jeff Schiff:

As you know now, I have trouble keeping quiet. So I think I already played my hand and said I think I agree with Kim. I think I want to be very more specific, though, is that I think I want to prioritize access, because I've had families tell me that access to services is a quality-of-life issue. And then secondly, prioritize the existence of a functional and working care plan. And I'm just going to say I want to know how

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the folks feel about their providers, but I think for the level of work that we need to do, asking those questions, which could link to something that was objectively accessible, would be a good piece of work for CMS and AHRQ and everybody. Thanks.

Patricia Rowan:

Thanks, Jeff. Let's go to David. David Basel. David, if you're on the line, if you could just raise your hand and we'll be sure to unmute you. Okay. David might be having audio connections or had to step away, so why don't we ask Jay Berry. Jay, are you there?

Jay Berry:

I'll just go back to the comprehensive care planning. A great measure that can measure the action items that come out of these plans whether they get done or not. A second component would be measuring patients' unmet health care needs and trying to minimize those. And I would just advocate for consideration of patients and families being our source of truth for the quality of care of how those things are being done.

Patricia Rowan:

Great. Thank you, Jay. Dee Brown.

Dee Brown:

I'm like Jeff, I can't keep quiet. But I do agree. Our long goal here is really the care management effectiveness. I don't know that there's truly a measure out there that has been developed for use. I think it is the top of my list to show that. Second would be the SDOH. Third would be the diabetic measures that exist. So that's the easy button. So I really do think the care manager effectiveness is the true core of this program. And I just am working in multiple markets on what we audit for completeness in a care plan and how we look for SMART goals in a care plan and short-term and long-term goals and then actual discharge capabilities out of a health home program and kind of looking at the health home as a longer-term care management episode of care. So I don't know how we can get to what the right measurements are, but I think that's the work of our national partners to work collaboratively with us to come up with some kind of a care management effectiveness measure set that we could use in this program because I think it's a huge gap.

Patricia Rowan:

Thank you, Dee. Stacey Carpenter. Stacey, are you still on the line?

Stacey Carpenter:

Yes, I am. I was thinking the same thing as Dee as far as the care management effectiveness. I think the quality piece of it, I think, is really important. And then I would also go back to my second would be the SDOH.

Patricia Rowan:

Thanks, Stacey. Macy Daly.

Mackenzie Daly:

Hi. I agree with a lot of what everybody else has been saying. I think if we could make that, you know, include some more of those social determinants of health to try and see if those, you know, improving

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those drives better outcomes, you know, with things like hospitalizations and inpatient readmissions, I think that would be really interesting to kind of try and use these measures to be able to tell that story of, you know, once we address these surrounding factors in folks' lives, they're able to have better, safer, healthier outcomes. So that's where my brain goes for this one.

Patricia Rowan:

Thanks, Macy. Amy Houtrow?

Amy Houtrow:

Thank you. I really love hearing what other people have said because it makes me able to jump on board with their great ideas. But when I think about equity and getting kids what they need, obviously that's an issue around access. And those groups of individuals who are most commonly marginalized often have the most trouble achieving that access, getting what they need in terms of their health and community-based needs. And I would really hope that we would be thinking about, and maybe that's as part of care planning and demonstrating that, you know, what has been identified as a need is being met, or maybe that's from a different perspective. But I really think getting at actually improving outcomes for people who have been multiply marginalized and getting them what they need, so access, would be a direction that I would love to see the work go in.

Patricia Rowan:

Thank you, Amy. Raina Josberger.

Raina Josberger:

I really like the idea of the PAM, the patient activation measure. I agree with all the comments, and particularly the comment around CAHPS, see a lot of survey fatigue. But the patient activation measure is very interesting to me because given this intense care management program, I'd like to be able to measure the what of what it is and how it's potentially impacting folks and their ability to manage their condition. So I'm just suggesting that idea again.

Patricia Rowan:

Thanks, Raina. Looks like Arielle is no longer on the meeting, so why don't we go to Pam Lester.

Pamela Lester:

Hello. I really think the care plan is a high-priority gap, and I think some of the other things can be addressed through addressing the care plan, such as was spoke to earlier around the social determinants of health, the patient activation, and access through identifying elements that, based on the health home program, are important to have in the care plan, and then ensuring that those are addressed.

Patricia Rowan:

Thanks. It looks like we no longer have Amy Salazar, so why don't we go to Sara Toomey.

Sara Toomey:

Hi. This has really been a great conversation. I think for me, I would prioritize social determinants of health and then the care plan. I think those, for me, are the largest gaps. Thank you.

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Patricia Rowan:

Thank you. Laura Vegas. Laura, you might still be muted locally. Go ahead.

Laura Vegas:

Sorry, I didn't hear you call my name. I would say I would certainly prioritize the care coordination function in itself, and within that, of course, the care planning. Thanks. Enjoyed this great conversation.

Patricia Rowan:

And Jeannine Wigglesworth. Go ahead.

Jeannine Wigglesworth:

Hi. So I mean, in looking at the social determinants of health, I would really like to, you know, focus on how we can get that 40 percent down, because I think that is a very important piece when you look at how that impacts the higher levels of care and other factors. So if we could kind of figure out a way how to work at that, that would be probably the top priority.

Patricia Rowan:

Okay, great. Thank you, Jeannine. I think the only folks that we didn't get were Dave Basel and Jay Berry. Oh, no, we did get Jay. Sorry. So Dave, if you are on the line and want to add your thoughts here, feel free. Okay, and if that conversation brought up any new insights from Workgroup members on gaps or anything like that that you'd like to share, please also feel free to raise your hand at this time before we move into public comment. All right. Why don't we move on to the next slide? Now we would like to provide one last opportunity for public comment on gaps in the Health Home Core Sets as well as priorities for future measure development, testing and refinement.

So if you'd like to make a comment, please use the raise hand feature in the bottom right corner of the participant panel and we will give you the opportunity to share. I do see some folks from other states with health home programs on the line, so if there's anything from your experience you'd like to share, please do raise your hand. Or measure stewards, if you have any thoughts on the Workgroup members' comments on measure development and measure refinement, we'd love to hear those thoughts as well. And for my federal partners and federal liaisons. All right. Well, I'm not seeing any hands raised, so we will move on to the next slide, please.

So we have covered a lot of ground today and yesterday during our meeting, and now we're sort of starting to move into the wrap up and an opportunity to reflect on the meeting. So let's move on to the next slide.

This slide has an agenda for this section of our meeting. To begin, I'll take just a quick moment to recap the Workgroup's recommendations for updates to the 2025 Health Home Core Set. The Workgroup considered a total of five measures, including one measure suggested for addition and four measures suggested for removal. And just as a reminder, for a measure to be recommended for either addition or removal, it requires a yes vote from at least two-thirds of the Workgroup members. So thanks to everyone for your perseverance with the voting technology in this virtual meeting.

The one measure that the Workgroup considered for addition was the MLTSS-2 measure on comprehensive care plan and updates, and the Workgroup did not recommend that for addition. Of the four measures that were suggested for removal, the Workgroup recommended two measures for removal from the 2025 Health Home Core Set, and those were the PQI 92: Chronic Conditions Composite measure and the Screening for Depression and Follow-Up Plan measure, or CDF. As I have reflected a

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little bit on the Workgroup's discussion and recommendations over the past few days, there was kind of considerable discussion across the criteria in those three areas that we put forth. Folks talked a lot about the desirability of measures that were being considered and the appropriateness of those measures for Medicaid health home programs. We also talked a lot about the technical feasibility for states to collect data and calculate the measures that were being considered for Core Set reporting, some technical challenges that folks face in doing that. We also talked a little bit about the financial and operational viability of measures and how data makes its way from providers to the state and how that relates to state reporting capacity and the resources to report measures for CMS at the program level.

We also had a lot of conversation around using the Health Home Core Set to advance health equity through screening and referral for social drivers of health and measure stratification. And so now I would like to hear a little bit from Workgroup members on suggestions for technical assistance that CMS might be able to provide to help states with reporting Health Home Core Set measures. So are there any suggestions from the Workgroup on how we can build state capacity for calculating and reporting Health Home Core Set measures? I see Kim, you have your hand up. Can we unmute Kim?

Kim Elliott:

Hi. There are two areas that seem to rise to the top as we were talking through the measures during this meeting. One of those was the data sources and how states might be able to capture additional data sources for measure reporting, such as supplemental data, such as EHR data or information. So that's one area I think that there could be some thought and maybe technical assistance applied to. And the second area had to do with the race and ethnicity and how the states are able to capture more complete information. And, again, that might tie back into additional data sources as well. So those are the two areas that I think that some technical assistance from a national level might be helpful in identifying opportunities to really improve the reporting capacity.

Patricia Rowan:

Yeah, thanks for that idea, Kim. Other comments from the Workgroup on opportunities for state capacity building for Core Set reporting, technical assistance needs, or any thoughts on the best format for technical assistance? Macy Daly, you can go ahead.

Mackenzie Daly:

I think something that we kind of struggle with is just how do I --

Patricia Rowan:

Macy, your audio is in and out a little bit. I don't know if you could get just a little closer to your microphone.

Mackenzie Daly:

Yeah. So I would say in Rhode Island our biggest issue is just identifying the populations and the kind of criteria that go into each one and how somebody, you know, the minimum number of days that they have to be in the program and that kind of thing. And I know we've had to come up with workarounds. So I think that it would just be helpful to have a session to figure out, you know, what tools other states are using and how the best way to kind of narrow down those populations. Because once we have the population, it's a lot easier for us to get, you know, the information on them. But making sure we're meeting those eligibility requirements is something we've struggled with in the past.

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Patricia Rowan:

Thank you for sharing that, Macy. Dee Brown.

Dee Brown:

I think we had such robust discussions that I really appreciated around individuals with SDOH measures. And I would encourage CMS to maybe partner with a few states that do have health homes State Plan amendments to see if they could test that to look at the technical feasibility aspect of that measure that we talked about and see if that's something that they could provide technical assistance both to the state themselves for collecting the measure and then the health homes see how well it could be adopted. I think that's a feedback mechanism that would be very helpful to us as a Workgroup to understand what the health homes feel about a measure like that before we adopted it and asked for them to try to capture it. I'd rather test it out. So if CMS could offer technical assistance in that fashion, it would be great.

Patricia Rowan:

Thanks for that comment, Dee. Jeff Schiff.

Jeff Schiff:

I'm not sure if this is proper to bring up here, but I'll give it a whirl. Because Macy was talking about defining populations. I think one of the challenges for 1945A is the structure of the payment. There's not a huge incentive to do this program. And I wonder if CMS could support some technical assistance around defining populations or defining by providers how we could serve kids who have medical complexity or special health care needs by helping define a population that could qualify for 1945 and maybe be measured under some 1945A criteria where the 90 percent match is for two years rather than the smaller bump that's available through the ACE kids in 1945A.

Patricia Rowan:

Thank you, Jeff. Other thoughts or comments from folks on technical assistance opportunities and needs to help support state reporting? Okay. I'm not seeing any more hands raised, so we'll move on to the next topic. In the spirit of continuous quality improvement, we would also like to give Workgroup members an opportunity to suggest ways that our team at Mathematica can review or improve their annual review process for next year. So I know we had some discussion yesterday about muting and unmuting, but if folks have other thoughts on opportunities to improve, we are all ears. Dee Brown.

Dee Brown:

I just want to provide feedback on the Slido. I think that that was a really good tool and much improved from prior years, so thank you.

Patricia Rowan:

Thanks. Pam Lester, go ahead.

Pamela Lester:

I don't really have any feedback other than thank you guys so much for all of your work around this. I know there's a lot that goes on in the background, and I appreciate all of you guys' work on this.

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Patricia Rowan:

Thank you, Pam. We appreciate that. It is a lot of work getting ready for these meetings, and we appreciate all the review that Workgroup members do to come prepared for the discussions as well. Kim Elliott, go ahead.

Kim Elliott:

I don't have any suggestions for updates, changes. I think you guys do a fantastic job. What I would say is I really appreciate all of the pre-work that you do and all of the resources that you make available to the Workgroup members as we're reviewing and considering measures to add or remove. That is extremely helpful, and it just saves us a lot of time as we're preparing for these meetings. So thank you for that.

Patricia Rowan:

Thank you. And if there is information that folks wish you had in those materials or background resources that we send, please let us know that as well, too. We can be sure to incorporate them. Dee, go ahead.

Dee Brown:

This is more of a question. So I know that we've got technical feasibility issues, but health care is changing really, really quickly as evidenced by, you know, health equity and the social determinants of health movement and figuring out that health care, you know, starts with Maslow's hierarchy. And I think we're going to see rapid expansion of health care over time. So a curiosity question of, why is the technical feasibility required that it has been tested already in a Medicaid market in order to be included for consideration? Now, I'm not suggesting that -- like that SDOH measure that we talked about, there's a lot of limitations and we want to test it. But the criteria that we have to abide by, is that a HEDIS criteria, a CMS criteria? I'm just curious.

Patricia Rowan:

Yeah, I really appreciate that comment, Dee. And I think, you know, for the most part, we've had it as a criteria to be sure that, you know, feasibility considerations would be addressed or identified prior to rolling this out for, you know, the whole country and every state with a health home program or reporting Core Set measures. I'm going to ask my colleague Margo Rosenbach to weigh in. She's got a bit longer memory than I do around here. So go ahead, Margo.

Margo Rosenbach:

All right. I think it's a great question, Dee, and it's something that we spend a lot of time researching when we receive a measure that we have not been able to determine immediately its use widely in Medicaid or CHIP. But I think what we've learned over time, and I think today's conversation was a really good example of that, that there are codes that are used in Medicare, for example, very regularly, like the CPT-II codes or Z codes or, you know, other codes that are very common in Medicare that are not used in Medicaid. And so I think what we learn from experience over time is that the minimum technical feasibility criteria are important. It's not an unlimited real estate on the Health Home Core Set or Child and Adult Core Sets. And we want to make sure that they are feasible.

And, you know, and there's this tradeoff between desirability and feasibility, and then you add in viability in terms of the resources that are involved, and particularly as you think about moving toward mandatory reporting, that we do think that it's really important that there have been experience using the measure, at least to some extent, in Medicaid and CHIP. I think you've heard also from measure stewards or from actually in today's situation about the depression screening measure, about how it is being used in other federal programs, in the CCBHC program or the FQHC UDS program. But those programs have very

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different data system data capture than Medicaid and CHIP. There also was a really interesting conversation, I think, about measures being standardized across states. You know, the old Medicaid adage of you've seen one, you've seen one. Fortunately, I think it's a little bit better than that now with the standardization of data. But there still are variations.

We heard from New York yesterday in terms of some of the differences in how their inpatient data are captured. So we just think it's really important to have some evidence of experience. And I think that's one reason why we also wanted to do the round-robin today to go around and hear from everyone about the priorities for gaps measure, refinement measure testing, because I think CMS has come to appreciate the need for additional testing of measures where there are gaps and where there are priorities. And that applies to health homes as well as Child and Adult Core Set. And I would say that one of the measures at the top of the list is social drivers of health, given its priority for health equity. And like you said, you know, that's a very important topic right now across all Medicaid programs. So I think that just gives you a little bit of a flavor of why, over time, we have implemented that as a criterion, and then also why we're moving into a much more rigorous conversation about the need for measure testing and refinement so that we can try to move some of these measures more quickly into implementable, feasible, viable position on the Core Sets. Does that help or answer the question?

Patricia Rowan:

Thanks, Margo and Dee. Other thoughts or comments on opportunities to improve the annual review process?

Dee Brown:

I just got unmuted. Yes, that very much helps. Thank you so much for that explanation.

Patricia Rowan:

Okay.

Dee Brown:

And I do think that testing for feasibility would be smaller samples before we mandate something. So curious as to CMS's thought process on being able to kind of fast track some of these things that are changing so rapidly in health care.

Patricia Rowan:

Yeah. That's definitely on people's minds, and I like your point about using smaller samples before you go big. And I know we have other states on the phone and measure stewards. I would love to hear from other folks about this as well if there are other comments when we finish this conversation.

All right. Before we move into our last public comment period, are there any other reflections or thoughts from the Workgroup on any of these topics listed on the slide here? Okay. Why don't we move on to the next slide?

We'd like to give one last opportunity for public comment. So if folks from, as Margo said, other states or anyone in attendance at this meeting would like to make a comment, please, this is your chance to do so. Please use the raise hand feature in the bottom right of the participant panel, and we will make sure you are unmuted. All right. Well, move on. Next slide, please.

As we begin to wrap up, I want to again take the opportunity to thank our Workgroup members for your flexibility and your patience in conducting this meeting virtually. I would also like to give our co-chairs, Kim

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and Jeff, an opportunity to make any final remarks. So Kim, would you like to go first? Derek, can we make sure Kim is unmuted? Thank you.

Kim Elliott:

You just did unmute me. Yeah, I think that this was a really, really good meeting with a lot of really good discussion, and I think that the focus that we're putting on social determinants of health, health equity, really on the member being the center of everything that we're working on and ensuring that the measures really reflect quality being provided, quality care, quality services, and then, of course, getting eventually to the outcomes from the health home work. I think that all of the passion that I hear coming through from the Workgroup members that are living and breathing this every day is really critical to the selection of these measures. So I just want to say thank you to everybody for that, and thank you again to the Mathematica team and all of the federal partners that work so hard on this particular initiative.

Patricia Rowan:

Thank you, Kim. Jeff?

Jeff Schiff:

I'm going to echo Kim's thanks to Mathematica and to the federal partners. And I think that since this program came into existence, you know, 13 years ago, I think we've all been excited about the potential of Medicaid to help coordinate care for these folks. And I just want to thank everyone for being here, because I think we all have the same goal, to serve this population and to improve the care for these folks. So it's an honor to be able to work with all of you. Thanks.

Patricia Rowan:

Well, I want to thank both Kim and Jeff for their support and their willingness to serve as co-chairs of this group. You have been great sounding boards for our team, and we really appreciate your support throughout this journey. Next slide, please.

So by now, this slide probably looks pretty familiar, but just to make sure everyone knows what our next steps are, this slide lays out the key milestones for the 2025 Health Home Core Set Annual Review process. As you recall, our journey began together back on January 24th, and following that, we opened up a call for measures for Workgroup members to submit measures for addition and removal. We spent a lot of time with those measures between February and June, and we reconvened on June 13th to get organized for this week's meeting. So we're really grateful, again, for all the time that folks have taken to prepare for the meeting. It's very obvious from all of the discussion that folks had really done their homework and read up on all the materials, so we appreciate that.

Our next step will be to review and synthesize the discussion that happened over the last two days and prepare a draft report. That draft report will be made available for public comment in September, and at that point, Workgroup members and members of the public will have the opportunity to review and comment on the report. We will incorporate those public comments, and a final report will be released in October. From there, CMS will obtain additional input from interested parties, including other federal agencies and state Medicaid quality leaders, and make final decisions to release the 2025 Health Home Core Sets by December 31st, at the end of this year. Next slide.

So if anyone has any questions for our team about the content of this week's meeting or the annual review process generally, please feel free to email us. Our email address is here on the slide. It is MHH, for Medicaid Health Home Core Set Review, MHHCoreSetReview@Mathematica-mpr.com.

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And finally, one last 'thank you' to our Workgroup members, federal liaisons, measure stewards, and public attendees for all of your contributions and participation this week. We also want to express our appreciation to staff in the Medicaid Benefits and Health Programs Group and the Division of Quality and Health Outcomes at CMCS for all of your support. Finally, I'll give one special shout-out to our team here at Mathematica, without whom this meeting would not have been possible. Next slide.

Well, we wish everyone well. You'll hear from us in a couple of weeks when we have a draft report for public release. But this concludes the 2025 Health Home Core Set Annual Review process. Our meeting is now adjourned. Thank you, everyone.