Technical Assistance Webinar to Support State Reporting of the Child, Adult, and Health Home Core Sets: Less Frequently Reported Core Set Measures

May 7, 2024

Katie Booth:

[Slide 1] Hello and thank you for joining us for this Technical Assistance Webinar. My name is Katie Booth, and I'm part of the Core Sets Technical Assistance Team. Today we will be providing an overview of less frequently reported Core Set measures subject to mandatory reporting, hearing from states about reporting challenges and best practices, and highlighting resources that are available to states. My colleagues from the TA Team, Madelaine Spiering and Alli Steiner, will also be presenting today. We are joined by Gigi Raney from the Center for Medicaid and CHIP Services. We're also joined by other members of the Core Set's TA Team and my colleagues from the Division of Quality and Health Outcomes and CMCS.

Next slide, please.

[Slide 2] Before we begin, we wanted to cover a few technical instructions. All participants of today's webinar have entered the meeting muted. During this webinar, there'll be time for state discussion. To speak, please use the raise hand option; and we will call on you to speak. You can also enter comments in the chat. 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 Ctrl-Shift-A on your keyboard to enable closed captioning. This meeting is being recorded and will be posted on Medicaid.gov after the event. Finally, if you have any technical difficulties, please contact us by using the chat feature for assistance.

Next slide, please.

[Slide 3] For our objectives today, we will be focusing on three Core Set measures subject to mandatory reporting that are less frequently reported by states and/or frequently reported with deviations. Those measures are Developmental Screening in the First Three Years of Life, or DEV-CH in the Child Core Set; Screening for Depression and Follow-Up Plan, CDF, which is in all three Core Sets; and Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%), or HPCMI-AD in the Adult Core Set.

First, I will summarize FY 2022 reporting of the Core Set measures more broadly. Next, Maddy and I will provide an overview of the three measures and additional lessons learned from state reporting. Alli will then facilitate a discussion where we hope to learn from states about what they are doing to report these measures, including any best practices that they have identified. Finally, Alli will share TA resources available to states.

We encourage state participation in this webinar in the forms of questions and sharing of lessons learned. However, state-specific questions are best answered by the TA mailbox or in a one-on-one TA call, which can be arranged at the TA mailbox.

[Slide 4] We will start with an introduction to the measures and the context of FFY 2022 Core Sets reporting. The three measures that we are focusing on today are all subject to mandatory Core Set reporting, starting with the upcoming FFY 2024 reporting cycle. In addition, they are among the least frequently reported measures in the Core Sets; and states have reported challenges adhering to the technical specifications, particularly due to the codes that are required to report these measures. The Core Sets Reporting Final Rule notes that states are required to report on the mandatory measures in accordance with the technical specifications developed by the measure stewards. This is essential for being able to provide effective comparisons across states and deriving National Performance rates.

[Slide 6] This slide, which is adapted from the Child Chart Pack, which is available on Medicaid.gov, shows the number of states reporting the Child Core Set measures for FFY 2022. As you can see, the Developmental Screening in the First Three Years of Life measure was reported by 37 states, and the Screening for Depression and Follow-Up Plan measure was reported by 21 states.

We wanted to note that, even though the developmental screening measure isn't one of the least frequently reported measures, some states have reported this measure with substantial deviations because codes in their states are not specific to the developmental screening tools in the specifications. This deviation is not considered adhering to the Core Set technical specifications for the purpose of mandatory reporting. Several of the other less frequently reported measures were new to the Child Core Set, either for FFY 2021 or FFY 2022 reporting; and states we're still ramping up to report the measures.

[Slide 7] Similarly, this slide adapted from the Adult Chart Pack shows the number of states reporting the Adult Core Set measures for FFY 2022. Screening for depression and follow-up plan was reported by 23 states; and diabetes care for people with serious mental illness, HbA1c poor control, was reported by 15 states.

[Slide 8] Finally, this slide adapted from the Health Home Chart Pack shows 16 Health Home Programs, reported the screening for depression and follow-ups in measure for FY 2022.

[Slide 9] Now we'll pass it to Gigi Raney from CMCS to provide some remarks.

Gigi Raney:

Thank you so much, Katie. And thank you so much to everyone who is joining our webinar today. I wanted to just start off by letting you know that we appreciate all of the work that you've done over the years to prepare for mandatory reporting and voluntary reporting, and want to just remind you that we're here to provide technical assistance and support; to answer your questions, your emails, and schedule calls with us but that you guys have already done so much of this work and are in a really good place for reporting. So, we're just here to help take you that last mile, right.

So, for the measures we're talking about today, we recognize that these are challenging measures for state-level Medicaid and CHIP reporting and that is why they've been less frequently reported by states or reported with deviations. However, for Core Set Reporting in 2024, which I'm sure you all remember will open in fall of 2024, these measures are required to be reported by states as they are included in either the Child Core Set or our behavioral health measure on the Adult Core Set or are in the Health Home Core Set.

We also want to remind you, as Katie mentioned, that states need to report the measures according to the Core Set technical specifications. We did want to acknowledge that the data currently available might not be representative of all of the services being provided in your state, and we want you to know that we will take this into consideration when determining what data will be publicly reported for these measures. Specifically, for the Developmental Screening in the First Three Years of Life measure, states should ensure that they are only including the developmental screening tools that meet the criteria outlined in the technical specifications, which we will review in the upcoming slides. States that are including additional tools are not adhering to the Core Set specifications. We do recognize that this may be a change for some states in how you're collecting the measure and with the mandatory reporting rule, we have an opportunity to realize more consistency and comparability in measure reporting; and we deeply appreciate your efforts to help us get there.

One more thing we want to make sure that you're aware of is that we do plan to continue working with states and with the measure stewards to determine if there are pathways for making these measures more feasible to report. Thanks for the opportunity to share a couple of words and back to you, Katie.

Katie Booth:

Thanks, Gigi. Go to the next slide.

[Slide 10] Now Maddy and I will present an overview of the three measures.

[Slide 11] So the first measure we will review today is the Developmental Screening in the First Three Years of Life, or DEV-CH. This measure is defined as a percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. Oregon Health and Sciences University is the measure steward for this measure, and the data collection method is administrative or hybrid. The denominator for each rate includes children in the eligible population who turn the appropriate age during the measurement year. For the administrative specifications, the numerator for each rate is the children in each denominator who had a claim with CPT code 96110 before or on their birthday during the measurement year.

Next slide.

[Slide 12] The numerator definitions continue on this slide. So, for the medical record specifications, the numerator for each rate is the children in each denominator who had a screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented before on their birthday.

We want to call attention to the note on what is required in the medical record. Documentation in the medical record must include all of the following: a note indicating the date on which the task was performed; the standardized tool used; and evidence of the screening result or screening score. There are no exclusions for this measure.

[Slide 13] This slide covers the criteria for the developmental screening tools for the measure numerator. Please note these criteria because the 96110 code used to define the numerator often includes tools that do not meet these criteria. As shown on this slide, this measure is anchored to recommendations focused on global developmental screening using tools that identify risk for developmental, behavioral, and social delays. Tools must meet criteria related to developmental domains, establish reliability, establish validity, and establish sensitivity and specificity.

[Slide 14] This slide outlines examples of tools that meet the criteria mentioned on the previous slide and examples of tools that do not meet these criteria. We wanted to call out that this measure is intended to capture global developmental screenings only. Domain-specific tools such as those focused on socioeconomic development -- socio-emotional development, or autism, should not be included in the measure numerator and would not be considered adherent to the Core Set Technical Specifications. In other words, use of ASQ-SE and M-CHAT do not qualify for this measure.

States must carefully review the billing policies in their states when using the administrative only version of the specifications to ensure they include only global developmental screening tools.

[Slide 15] The number of states reporting the DEV-CH measure increased from 31 states for FFY 2020 to 37 states for FFY 2022. However, the note includes a couple of caveats about state reporting with deviations from technical specifications. For FFY 2020 reporting, one state reported that it used other specifications. In addition, across the three reporting years, several states reported that they deviated from the technical specifications, including counting codes that were not limited to global developmental screenings.

Beginning with FFY 2024 mandatory reporting, CMS would count these states as using other specifications; and this will not meet the requirement for adhering to the technical specifications.

[Slide 16] We wanted to acknowledge a few of the key reporting challenges states have reported. States have flagged challenges related to available data, including that CPT code 96110 is not available for use in the state. Screening tools allowed for CPT code 96110 under state guidelines do not align with the intent of the measure, and that medical record review is required for states that cannot calculate this measure accurately using claims data. States also reported that they experienced data inconsistencies or data accuracy issues.

Now we'll pass it to Maddy to go over the next two measures.

Madelaine Spiering:

[Slide 17] Thanks, Katie. The next measure we will review is Screening for Depression and Follow-up Plan, or CDF-CH, AD, and HH. This measure is defined as the percentage of beneficiaries 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 the qualifying encounter. As a note, the qualifying encounter is an outpatient visit during the measurement year identified through CPT and G-Codes.

We want to note that this measure is intended to promote primary prevention as well as integration of primary care and behavioral healthcare. This measure focuses on the population that has not previously been diagnosed with depression or bipolar disorder.

The measure steward is the Centers for Medicare and Medicaid Services, or CMS, and the data collection method is administrative or EHR. Please note that this measure is not specified for hybrid methodology using medical chart reviews.

This measure is collected for the Child, Adult, and Health Home Core Sets.

The denominator for this measure is the eligible population with an outpatient visit during the measurement year.

The numerator for this measure is defined as beneficiaries 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 the qualifying encounter. The numerator is calculated using one of the following codes -- G8431: where screening for depression is documented as being positive, and a follow-up plan is documented; or G8510: screening for depression is documented as negative, a follow-up plan is not required.

Next slide, please.

[Slide 18] This slide lays out the exclusions and exceptions for this measure.

For exclusions, as I noted earlier, a beneficiary is not eligible if they have been diagnosed with depression or bipolar disorder.

For exceptions, a beneficiary that does not meet the numerator criteria and meets the following exception criteria should be removed from the measure denominator for the following beneficiary and medical reasons -- First, the beneficiary reason is that the beneficiary refuses to participate. And there are two medical reasons: the beneficiary is in an urgent or emergent situation where time is of the essence, and to delay treatment would jeopardize the beneficiary's health status; and situations where the beneficiary's cognitive, functional, or motivational limitations may impact the accuracy of results.

Next slide.

[Slide 19] On this slide, we show the number of states reporting the CDF measure for FFY 2020 through FFY 2022. As you can see, state reporting has increased over time; but we recognize that there are still some challenges reporting this measure for many states. For example, some states reported using other specifications, such as the hybrid methodology, to report this measure. And, as I mentioned earlier, the hybrid methodology is not considered adhering to the technical specifications for the purpose of mandatory reporting.

We would like to note that this measure is frequently reported by providers in the Medicare Merit-based Incentive Payment System, or MIPS. However, CMS understands that the codes used to calculate this measure are often not available for state-level Medicaid reporting.

Next slide, please.

[Slide 20] CMS conducted outreach to states that reported the CDF measure to understand their challenges, lessons learned and technical assistance needs. Thank you to those of you who provided feedback.

States communicated that Medicaid providers do not consistently use the G-Codes required to calculate the numerator. It was noted that often these G-Codes are not reimbursed, and many states feel their rate substantially underreported depression screening and follow up in their state.

We wanted to highlight that a couple of states let us know about some promising best practices for improving reporting for the measure, including conducting provider education about the G-Codes to increase the use of codes in claims. These states reported increased use of the codes by providers.

Next slide.

[Slide 21] We reviewed the reasons for not reporting for CDF-CH, -AD, and -HH for FFY 2022 and found similar themes such as inconsistent use of G-Codes by providers; codes included in the measure are not billable or widely used; states use other types of psychometric assessments; or the state prefers to use EHR data, which is not currently available.

Next slide, please.

[Slide 22] The last measure we will review is Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (greater than 9%). The measure is defined as the percentage of beneficiaries ages 18 to 75 with serious mental illness and diabetes type 1 and type 2 who had hemoglobin A1c (HbA1c) in poor control or greater than 9%.

National Committee for Quality Assurance, or NCQA, is the measure steward. The data collection method is administrative or hybrid.

The denominator for this measure is beneficiaries who are ages 18 to 75, as of the end of the measurement year; have a diagnosis of a serious mental illness; and have diabetes. The slides and the technical specifications provide more detail about the denominator criteria.

Next slide.

[Slide 23] For the administrative specifications, the numerator is defined as a beneficiary whose most recent hemoglobin A1c level is greater than 9% or is missing a result, or if the hemoglobin A1c test was not done during the measurement year.

We would like to note numerator compliance can be determined through lab value sets or CPT category II value sets. States that use CPT category II codes to identify numerator compliance must search for all codes in the four value sets referenced in the specifications and use the most recent code during the measurement year to evaluate whether the beneficiary is numerator compliant.

For hybrid specifications, the numerator is defined as beneficiaries whose most recent HbA1c level performed during the measurement year is greater than 9% or is missing or was not done during the measurement year, as documented through laboratory data or medical record review.

Next slide, please.

[Slide 24] This slide outlines the exclusions for this measure.

Next slide.

[Slide 25] On this slide, we show the number of states reporting HPCMI-AD. As you can see, the number of states reporting has increased over time, but CMS recognizes that many states are still having challenges and that there is a variation in the data reported across states.

Next slide.

[Slide 26] We reviewed the reason states gave for not reporting this measure for FFY 2022, and states noted challenges with data availability, including limited use of CPT category II codes and hemoglobin A1c values are not available in claims data. Also, this measure requires medical record review for states where administrative claims do not include numerator codes.

Next slide.

Now, I will pass it over to Alli to lead the state discussion about these measures.

Alli Steiner:

Thanks, Maddy. Next slide, please.

[Slide 28] So we'd like to dedicate most of the rest of this meeting to hearing from states about their experiences calculating these measures. And, before we begin, we'd like to share a few goals for the discussion. We understand that there are challenges with these measures, and we hope to keep this discussion as solution-focused as possible. We ask you to build on previous comments and to not repeat challenges that have already been stated. And if you're making changes or trying new approaches to report these measures, we'd love to hear about those efforts.

So next slide, please.

[Slide 29] We'll start by discussing the developmental screening measure. We've included some questions to prompt the discussion. So, for example, if your state is calculating the measure, we'd like to hear about your approach and any lessons learned, particularly for ensuring that you're only including global developmental screenings that meet the measure criteria. If your state doesn't report the measure, we'd like to hear about what you've tried, whether you have questions for other states, or if you have specific TA needs. And so, at this point, we'll open it up to hear from states. And, as a reminder, if you'd like to make a comment, please raise your hand, and we'll call on you, and we'll unmute you. When we unmute you, please state your name and affiliation. You can also enter comments in the chat. So, with that, it looks like we have a hand raised from Paul Kirby. Derek, can you please unmute Paul Kirby.

Paul Kirby:

Hi Everyone. Just wanted to jump in on -- I'm sorry, Paul Kirby with Massachusetts Medicaid, MassHealth. So our experience is we've been reporting the measure for a number of years but kind of have been doing it knowing that it's probably been incorrect because of a lack of clarity in terms of how to narrow down to just the exact kind of screening that's wanted here. In this past measurement cycle for FFY 2023, I was able, finally, to get some clarity on those modifier codes and start excluding some modifier codes that apparently were an autism-specific screening and so really, you know, should never have been included in the measure in the first place. So that did have the effect of lowering the scores for us by about, give or take, close to 10 percentage points across the different age groups. So clearly, you know, we had been including some things that we shouldn't have been in the past but now we seem to be doing it correctly, so that's progress.

Alli Steiner:

Well, thanks, Paul. Thanks for sharing that story. I think that's probably something a lot of states have experienced, and we appreciate Massachusetts' efforts to really take a look at those codes and make sure that only the global developmental screenings are included. So, thanks for sharing that. Do you have any other tips for states about how you went about that process of identifying the correct codes? Sorry to put you on the spot there.

Paul Kirby:

Okay, well, not really because I think this stuff is idiosyncratic. I kind of just found out about it because somebody, one of my colleagues who had been working -- let me back up a little bit. We have an

Accountable Care Organization Quality Program that has been in place since our last waiver, so about five years now; and through that program, my colleagues have been incorporating a number of measures, including this one just recently, which they've added to that ACO slate. And my colleague and his team were basically working on the specification and kind of dug into it probably via sort of like our sub regulatory guidance, which is something that probably most states have in terms of really specifying the nuts and bolts of measures. And, basically, he just informed me that I might want to, knowing that I worked on the Core Sets and did this measure, just tipped me off that they had refined the measure.

So, to be honest, I kind of found out by fortunate accident. You know, state Medicaid programs are big organizations and often are siloed, we certainly are. So, I guess the tip would be talk to your colleagues as much as possible, if you feel that -- if you are concerned that you are including screens that shouldn't be. I guess that's really the only meaningful advice I can give.

Alli Steiner:

Yeah, thanks, Paul. I also want to say also we saw you put a comment in the QMR system about noting this change in performance rate, and we would encourage states to do that. It's helpful to have that context for CMS's awareness if there is a change. So, thank you so much, Paul.

I also see we have a hand raised from Becky. Can we please unmute Becky?

Becky Breidenbach:

My name is Becky Breidenbach and I'm with Washington State Healthcare Authority. We had kind of a similar experience as Massachusetts. Back in 2021, we changed our billing guide to remove the social emotional screening tools such as the ASQ-SE from under CPT code 96110. So, we started reporting in 2022, due to the look-back period, and we thought we were in line with Core Set specifications until very recently we realized our billing guide still includes the autism screening.

So, as Massachusetts did, I found out about the ICD-10 modifiers and realized that, when I pulled some data, only about 17% of our claims with that CPT code had a modifier, about 11% have the general screening code, and about 7% had the autism screening code. I checked with our billing guide subject matter experts, and they said that we cannot assume that if no modifier is present, that a general screening was done. So we're going to start the process of updating our billing guides first by recommending the use of the ICD-10 modifiers so that we can determine whether it was a general developmental screening or an autism screening. So, we're going to update that this coming July, we're going to gather feedback and then hopefully require the use of the modifiers. However, our clinical team said that it will take several years to see consistent use of the modifiers. So, for next year, we're only going to include individuals with general screening ICD-10 modifier, knowing that this is going to be an underestimate of the actual rate of screening until the billing guide and practice catches up and it's going to reduce our rates significantly, so we will put that note in.

Alli Steiner:

Thank you, Becky. Thank you for sharing that story and for all the work you're doing to update the modifiers.

I saw we had another hand. Eddy, did you want to make a comment or believe you've lowered your hand. Can we please unmute Eddy Myers?

Eddie Myers:

Eddie Myers from Louisiana. I just wanted to comment that in the past we had the problem of not having very much use of that CPT code for developmental screening and in February of '21 the state issued a policy that covers that code and that indicates that it should be used for AAP Bright Futures Standardized Screening Tool. And so that, for last year reporting, '23 reporting for measurement year '22, we were able to report, you know, a more accurate rate for the first time.

Alli Steiner:

Thanks, Eddy. That's great that you're able to do that in Louisiana.

We have Mark, Mark's hand is raised. Can we unmute Mark, please.

Mark Rizzutti:

It's Mark Rizzutti from Ohio Medicaid. I was just wondering what the data source was for the modifiers that you've been talking about and are they included in the CMS Core Set Value Sets or are not?

Alli Steiner:

Yeah, thanks, Mark. I can answer that question. So, just to clarify, the measure does not require use of modifiers. However, it states that they *can* be used depending on the intent of the modifier in your state. So, the specifications give some examples of modifiers; they give some examples of cases where modifiers should and shouldn't be used. So, I would encourage you to take a look at the technical specifications but, if you have specific questions about modifiers, whether or not they meet the intent of the measure and you could provide maybe some state-specific context about how those modifiers are intended, we'd be happy to take your questions through the TA mailbox and potentially follow up with the measure steward to confirm.

Mark Rizzutti:

Okay, thanks.

Alli Steiner:

Let’s give another minute to see if there are any other comments or questions.

We did receive a question about what an ICD-10 modifier is. So, some billing codes will have a modifier attached to it. So, for example, the specifications give an example of the Z13.42, which can be used to indicate an encounter for global developmental delays, so that's just one example. But this would be something attached to the claim that would give further guidance on the intent of how that code is being used in that particular state. So, it would be used in addition to the CPT code that's specified in the measure.

We're getting a few comments in the chat. So just give me one second.

We have a comment from New York that says: in New York State, we have created a measure that requires a CPT code 96110 and ICD-10 code Z13.42. We require the plans to calculate and submit this measure.

We have a question in the chat, Tenaya, about regulatory guidelines. I'm not sure I'm following the question. Would you be able to raise your hand and ask your question off mute? Can you please unmute, Tenaya. Thank you.

Tenaya Sunbury:

Regards to what Paul Kirby was saying from Massachusetts about regulatory guidelines, and I just wanted to clarify if he meant the billing guides. He also alluded to, you know, the siloing from certain areas in states, I certainly agree. That could certainly be a solution or something that states have to think about. You know, the person who is calculating the core metrics, where are they in relation to folks who put the billing guide together that specify which codes providers are using and submitting to the state for billing.

And, you know, one of the things that Becky mentioned from Washington, I'm also from Washington, was that, you know, she works very closely and with those billing guide folks to find a solution and, you know,

kind of think of some corrective actions. So you know, sort of like maybe Paul can speak to some of that a little bit, like finding out where some of those silos are and/or just finding the point person is sometimes a huge challenge. And so I just wanted to ask him if that's what he meant when he meant regulatory guidelines. Thank you.

Alli Steiner:

Thanks for that question. Paul, are you able to speak to that? If you wouldn't mind raising your hand, we can unmute you. Otherwise, we can also take this offline. Thanks. Can we unmute Paul, please?

Paul Kirby:

Yes, hi. Yeah, I think that's basically right. I didn't know quite what the terminology to call it is. I think billing guide is pretty reasonable. We specifically here call it, I think, provider letters or provider notifications or something. And they're very official when they come out from the agency to the relevant, you know, provider communities. And they also -- I think they have, as a legal matter, they have the force of like a sub- it's not a regulation, but it's a sub regulation. So it's kind of like the law, but it's only really codified in this letter. I don't know. It's all very complicated, and I don't really understand it well. But, yeah, I think billing guide to providers, if that captures it. It's like, “Hey providers, we know you want to get paid for the things that you do. So here’s the latest instructions on how to code things to make sure that you do get paid.” So, it's basically that.

And, you know, as far as finding the right place in terms of silos, I don't know, it's really hard. I mean, I've been at MassHealth for a really long time. Just, boy, it's hard. I mean, especially if you haven't been with your organization for all that long, it just takes time. So sorry. I don't really have a good answer for that one. Just talk to as many people as you can, I guess.

Alli Steiner:

Thanks, Paul. And, interest of time, let's move on to the next measure. We want to make sure to save time to talk about the next two measures, so we'll move to the next slide, please.

[Slide 30] So we'd like to have a similar discussion around the CDF measure. In particular, we'd love to hear what states are doing to increase use of the G-Code. For example, we've heard from a couple of states that they did provider outreach to increase use of the codes and we're wondering if other states have tried that or if you have any other solutions or suggestions. So, if your state has any comments to share about best practices, we'd love to hear from you or something you've tried.

Looks like we have Jeannie, Jeannie's hand is raised. Can we unmute Jeannie, please, Derek.

Jeannie Wigglesworth:

Can you hear me?

Alli Steiner:

Hi, yes, we can.

Jeannie Wigglesworth:

Oh, hi, hi. Yes. This is Jeannie Wigglesworth, and I'm from Connecticut. I'm from Carelon Behavioral Health. We are the ASO under the Department of Social Services and I'm the Director of the Health of the Medicaid Health Home here. Our focus is on the SMI population, coordinating care with medical health providers. And some of the issues we've run into is that our behavioral health providers do depression screens on a regular basis and are required for, you know, a lot of other requirements outside of this measure.

Also, our target population is SMI population, so often, you know, we use a little bit of a broader stroke for SMI, which includes major depression. So, a large majority of our population have already been diagnosed with depression. However, we do depression screens oftentimes not on an outpatient visit but in different venues or forums. So, we were not getting too many hits, so to speak, out of claims using the G-Codes. And, also, prior to July of 2022, there was, I think it was a 9 code that they were using to bill with two modifiers for the depression screen and in July of 2022 they, Connecticut, changed that to the G-Codes for billing. So, we've been looking at claims, and we have seen that the use of the G-Codes have doubled since between '22 and 2023, so we're hoping that's promising.

We've also reached out, within the health homes, we meet with them on a regular basis. So we have a good picture of how and when they're doing the depression screens. And we created a data source within Carelon's EHR system for them to enter depression screens, as well, because we knew that claims was an issue of getting those depression screens.

And I guess my only comment for maybe improving is I think this measure is beneficial, but I feel like it really has, you know, two maybe distinct purposes. And one is really geared more towards the health home that is maybe the medically based health home and different purpose really for the behavioral health health home. I think the method or the intervention of doing the depression screens is very different. So, I don't know if the measure can be different or if just realize that the process may be different in collecting information for this measure that way.

Alli Steiner:

Yeah. Thank you, Jeannie. Thank you for those comments about how you worked to increase the use of those codes. And you bring up a good point., I think this measure is intended to capture primary prevention in those who have not yet been diagnosed and so you make a good point that the application might be quite different in the general Medicaid population versus a population that is specifically, you know, -- has already been identified as having some of these diagnoses. So there's definitely some nuance in application there. So thanks for flagging that, and thank you for sharing your state’s, Connecticut's, efforts to increase the use of those codes.

I will mention we heard similar -- I should say we heard some feedback from Hawaii that they said we could share. They weren't able to join on this call at this time, but they mentioned that one of their managed care plans has provided a lot of provider education. They're specifically working with providers and other office staff on the use of the codes, and they've been working with the providers and office staff to identify barriers and establish new workflows that encourage the use of those codes.

Do we have any other states who have questions for other states or have tried something in their states to encourage use of codes that they could share or anything they're thinking of trying to do? Maybe you don't have the results yet but something you're considering in your state that might provide some insights to other states.

We have a question. Let's see. Looks like Becky has -- Becky's hand is up. Can we unmute Becky, please, Derek?

Becky Breidenbach:

Hi, this is Becky Breidenbach from Washington State HCA again. So you asked what we were doing in regards to this, and we did share this on a TA call with CMS. But since there was some pushback to using the Medicare G-Codes for Medicaid billing and requiring them since they're really a reporting code, we are looking at using the CPT codes with modifiers to indicate whether the screening was positive. They're U modifiers, and we're using them to indicate whether the screening is positive or negative and it requires a follow-up plan as well. So that's our alternative to using the G-Codes because it seems that we will not be able to require them.

Alli Steiner:

Thanks, Becky. Yeah, I know we did talk about that on a TA call, and I think, in cases like that, we would want to follow up at the measure steward and just make sure that it's considered adherent to specification. So, we'll definitely follow up with you about that and if any other states have questions about specific codes that they are considering, please do let us know. We'd love to hear about that and also coordinate with the measure steward. Thanks for bringing that up.

Let's see. I think we had a question, Tara, in the chat. Do you mind, are you able to raise your question out loud about data sources?

Or I can read the question. There's a question about if there are any plans to utilize other external sources not codes from claims? So I'll just say that currently the measure is specified for claims administrative data and EHR data. I'm not aware of any plans to change that, I think that would have to be something taken back to the measure steward.

One question we received when the TA team did outreach to states was whether other states are paying for G-Codes because it sounded like some states were not. If there are any states that are paying for G-Codes or any states that recently started paying for them, any states that started recently reporting this measure that has anything that they could share. We're interested in hearing anything about that process and how you got to start reporting this measure.

All right. Well, at this point, I'm not hearing a lot of comments. You know, if you think of anything you wanted to send offline, we'd be interested in hearing any solutions that come to mind. But we will move on to the next measure.

[Slide 30] So we'll talk about the HPCMI measure now. We understand that states have some similar challenges with the codes available to report the measure, especially using administrative data alone and we'd love to hear what approaches your state has taken. For example, does your state report using administrative data only or using the hybrid method? Has your state done anything to increase the use of codes needed? So, are there any states that have been reporting the HPCMI measure that could share any insights into their approach?

Just a reminder, if you can raise your hand, we'll make sure to call on you to come off mute. Paloma. Derek, can you unmute Paloma, please?

Paloma Luisi:

I'm from New York, hi everybody. This is Paloma Luisi. We do report this measure, but yes, we have to do it hybrid. So, you know, we pull it in from the poor HbA1c control data that we get from the plans, and then we use our member level file to identify members with a serious mental illness diagnosis using a code from our sister agency, Office of Mental Health. But that's to say it does need to be hybrid because, overall, the administrative rates of the measure are twice, this is a measure where lower is better, twice that when we look at it administratively. And that is because the CPT II codes that could collect a lab value that require, you know, sort of a pretty set parameter of dates are not being done systematically across the plans. When I look at the data, I see some plans seem to be close, but nobody's within the realm of being able to do it administratively and having a good result. So, we're relying on hybrid data for this time, and that's why we've been submitting hybrid in our Core Set Reporting to you all.

Alli Steiner:

Yeah. Thank you, Paloma. Thanks for sharing the New York experience. We appreciate that.

Paloma Luisi:

I'd love to know if other people have the same problem. I think that's probably it, but thank you.

Alli Steiner:

Yeah, thanks. We'd love to hear from other states, as well, in response to the questions you raised.

I see David Kelly has his hand raised. David, are you able -- Derek, can you please unmute David?

David Kelly:

Good afternoon and hopefully you can hear me.

Alli Steiner:

We can. Thank you.

David Kelly:

Okay. In Pennsylvania, we have been reporting it via administrative data. And I'll say that our results are more than double the hemoglobin A1c for control than the general population. And, again, lower is better. So there is a very big difference between what we report for the hemoglobin A1c poor control for the general population, which I believe we still use the hybrid methodology. So, with that being said, we have -- our MCOs for many years, were allowed to send to providers an incentive to gather quality measures electronically and that was kind of vaguely worded. Some of our plans interpreted that as working with providers to get them to use CPT II codes for, I believe, high blood pressure and for diabetes. So, some of our plans, because of that past activity, have relationships with larger volume practices, perhaps some of our patients that are in medical homes where they are able to gather information, you know, using the CPT II codes. Can't recall if the SNOMED codes, I think they're allowable as well.

So I know that one of our plans who performs better than some of the others has particularly spent a lot of time and energy on that effort. And then another one of our plans that also is part of a very large health system may have other -- have similar relationships with those high-volume practices where they're able to pull the CPT II codes or SNOMED codes from those practices and/or labs. So I will say that it would really be interesting if we did a hybrid to see the comparison between what we're reporting administratively versus hybrid. But it is what it is, and we're going to continue to work with our MCOs and practices to really try to get as much information as we can.

And I'll go back to the previous two measures. One strategy that we've used with some success is we have learning networks for our patient-centered medical home. And many states have health home programs. And if you have a learning network, that may be a good opportunity, you know, outside of sending, you know, an email with a bulletin or billing instructions, actually covering that during the Learning Network and then showing them how to actually go through add that, put those codes and add them onto the claim so that they're getting credit for it. So that may be another strategy for the previous two measures. So that's what we're doing. No great magic here. And, you know, our results are less than stellar, let's put it that way.

Alli Steiner:

Thanks, David. Still very helpful for you to share those strategies. And thanks for the work that Pennsylvania is doing to try to increase the use of those codes. So, thanks for sharing those comments.

And, in the interest of time, let's move on to the next slide, please.

[Slide 32] So just a couple of quick follow-up notes. So first of all, thanks to the states that chimed in with what they're trying. We want to just reiterate that CMS understands these measures present challenges, but states should adhere to the technical specifications and report the data, even if the rates are low or high, depending on the measure. And, as Gigi mentioned earlier, CMS will take data quality into consideration when determining what to publicly report.

And so, we heard from a few states about their approach to reviewing billing policies or increase the use of G-codes. We also heard from states that they think that medical record data for each HPCMI is more reliable. And so CMS and the TA team will definitely take back what we heard and think about how to use this information to make reporting more feasible.

And we just wanted to also remind folks that, on May 13, there'll be an office hours where we can continue discussing these measures.

So, if we go to the next slide, please.

[Slide 33] And we'll go to the next slide, please.

[Slide 34] So, just as a reminder, we encourage states to reach out to the MACQualityTA mailbox with any questions about these measures or just set up a one-on-one session. And, as I just mentioned, there's going to be an office hours on Monday, May 13, at 2:00 p.m. Eastern where we'll continue this discussion.

We also wanted to flag that CMS recently posted a Frequently Asked Questions resource that covers topics related to mandatory reporting. It's available on the Reporting Resources page on Medicaid.gov. And these slides will be posted along with the recording in the coming weeks on Medicaid.gov.

In September, CMS will host a webinar on Reporting the Core Set Measures and the online reporting system, including highlighting system changes related to mandatory reporting.

Next slide, please.

[Slide 35] So, on the next few slides, we've listed technical assistance resources available on Medicaid.gov. We've gone through these in previous webinars. So, in the interest of time, we won't go through them. But we just wanted to remind states that they're available.

Next slide, please.

[Slide 36] Next slide, please.

[Slide 37] And we'll go -- next one.

[Slide 38] We'll go over stuff on this slide real quickly. This is as a reminder. I just mentioned there's a new Frequently Asked Questions resource on Medicaid.gov. Also, the stratification resource for FFY 2024 reporting was recently posted.

Next slide, please.

[Slide 39] And one more slide, please.

[Slide 40] And so, with that, we'd like to thank everyone for participating in today's webinar. We encourage you to please take a moment to complete the evaluation as you leave, including any ideas for other helpful future TA topics. And so, with that, thanks, everyone, for your participation. And we hope you have a nice rest of your day.