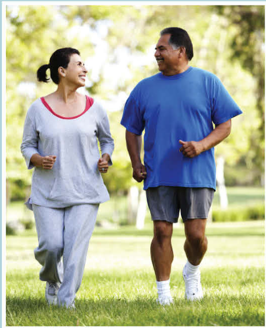

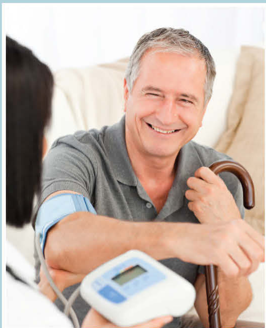

Quality of Care for Children and Adults Enrolled in Medicaid Health Homes: Findings from the 2020 Health Home Core Set

Chart Pack

February 2022

This chart pack is a product of the Technical Assistance and Analytic Support for the Medicaid and CHIP Quality Measurement and Improvement Program, sponsored by the Center for Medicaid and CHIP Services. The technical assistance team is led by Mathematica, in collaboration with the National Committee for Quality Assurance, Center for Health Care Strategies, AcademyHealth, and Aurrera Health Group. This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

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About the 2020 Health Home Core Set

Medicaid health home programs provide person-centered, team-based care coordination to more than one million Medicaid beneficiaries with chronic conditions. States may create health home programs that target specific conditions, including multiple chronic conditions, severe mental illness, or substance use disorder. As of December 2021, 21 states have 37 approved health home programs, with some states submitting multiple state plan amendments (SPAs) to target different conditions.[1,2]

Health home programs provide the following core services to enrollees:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support
- Referral to community and social support services[3]
- The use of health information technology to link services, as feasible and appropriate

As a condition for receiving payment for health home services, health home providers are required to report quality measures to the state.[4]

This Chart Pack summarizes program-level reporting on the quality of health care furnished to Medicaid beneficiaries enrolled in Medicaid health home programs reported in federal fiscal year (FFY) 2020, which generally covers care delivered in calendar year 2019 (January 1, 2019 through December 31, 2019). The slides include a summary of reporting on nine quality measures and three utilization measures.[5]

9

measures that address quality of care and

3

measures that address utilization of services among enrollees in Medicaid health home programs

[1] The term "states" includes the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, the Northern Mariana Islands, and American Samoa.

[2] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-spa-overview.pdf

[3] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf

[4] §1945(g) of the Social Security Act

[5] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/2020-health-home-core-set.pdf

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OVERVIEW OF REPORTING OF THE 2020 HEALTH HOME CORE SET BY APPROVED HEALTH HOME PROGRAMS

Number of Approved Health Home Programs by Target Conditions, FFY 2018–FFY 2020

Approved health home programs may target different conditions. From FFY 2018 to FFY 2020, the number of approved health home programs increased in each reporting cycle, driven by an increase in the number of programs serving beneficiaries with substance use disorder (SUD) and programs with two or more focus areas. In FFY 2020, 37 approved health home programs served beneficiaries with serious mental illness/severe emotional disturbance (SMI/SED), chronic medical conditions, SUD, HIV/AIDS, or a combination of these conditions.

Number of Approved Health Home Programs

	FFY 2018	FFY 2019	FFY 2020
HIV/AIDS	1	1	1
SUD	2	3	4
Hybrid	5	6	7
Chronic Conditions	8	9	9
SMI/SED	16	16	16
Total	32	35	37

Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, April 2021.

Note: Hybrid health home programs refer to those that have two or more areas of focus (e.g., SUD and SMI/SED). Focus areas may have been updated since the publication of the 2020 Health Home Chart Pack.

Geographic Variation in Health Home Programs Expected* to Report Health Home Core Set Measures, FFY 2020

- 0 Programs
- 1 Program
- 2 Programs
- 3 Programs

Note: * For the purpose of this Chart Pack, “expected” is defined as those states meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period). This chart shows the number of approved health home programs in each state that were expected to report Health Home Core Set measures for FFY 2020.

Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, April 2021.

Summary of Health Home Core Set Reporting, FFY 2018–FFY 2020

CMS encourages states to report the Health Home Core Set measures for each approved health home program that has been in effect for at least six months of the measurement period. From FFY 2018 to FFY 2020, both the number of approved health home programs expected* to report and the number of programs reporting at least one Health Home Core Set measure have increased. Of the 37 approved health home programs expected to report for FFY 2020, 34 reported at least one measure.

Number of Approved Health Home Programs

40
35
30
25
20
15
10
5
0

FFY 2018: 30, 32
FFY 2019: 31, 35
FFY 2020: 34, 37

Number of Programs Reporting At Least One Measure
Number of Programs Expected to Report

*For the purpose of this Chart Pack, “expected” is defined as those states meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period).

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021. FFY 2018 data reflect reporting as of September 13, 2019; FFY 2019 data reflect reporting as of July 27, 2020.

Number of Health Home Core Set Measures Reported for Approved Health Home Programs, FFY 2020

Health Home Program	Measure calculated using Core Set specifications	Measure calculated using other specifications	Total
Connecticut Serious and Persistent Mental Illness			12
Dist. of Col. Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions			12
Dist. of Col. Chronic Conditions			12
Maryland Health Home Services			12
Oklahoma Health Home (Adults)			12
South Dakota Health Home			12
Missouri Community Mental Health Center Health Home			11
Missouri Primary Care Clinic Health Home			11
Iowa Severe and Persistent Mental Illness Health Home			10
West Virginia Health Homes for Individuals with Chronic Conditions	9	1	10
Wisconsin Individuals with HIV/AIDS			10
Iowa Health Home Services			9
Maine Behavioral Health Home			9
Maine Health Home for Beneficiaries Receiving MAT for Opioid Addiction			9
Maine Stage A Health Home Targeting Individuals with Chronic Conditions			9
Michigan Care Team			9
Michigan Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions			9
Minnesota Behavioral Health Homes			9
New Mexico CareLink			9
New York Health Home Services	6	3	9
West Virginia Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C			9
Rhode Island Opioid Treatment Program Health Home Services	3	5	8
Washington Health Home Services			8
Michigan Opioid Health Home*			7
New York I/DD Health Home Services	5	2	7
Rhode Island Community Mental Health Organizations Health Home	4	3	7
California Health Home Program			6
Alabama Health Home			5
North Carolina Community Care Health Home			5
Oklahoma Health Home (Children)			5
Rhode Island CEDARR Family Centers Health Home			5
California Behavioral Health Home*			3
Tennessee HealthLink Health Home Program			3
Delaware Assertive Community Integration Support Team (ACIST) Health Home*			2

Number of Measures (axis: 0, 2, 4, 6, 8, 10, 12)

Legend: Measure calculated using Core Set specifications; Measure calculated using other specifications

Health home programs reported a median of **9** Health Home Core Set measures for FFY 2020

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: The FFY 2020 Health Home Core Set includes 12 measures. * = State was expected to report for the health home program for the first time for the FFY 2020 reporting period. For the purpose of this Chart Pack, “expected” is defined as those states meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period). The New Jersey Behavioral Health Home Adult and Children programs and Vermont’s Health Home for Beneficiaries Receiving MAT for Opioid Addiction are not included, because they did not report data for FFY 2020 by the deadline. Unless otherwise specified, states used Health Home Core Set specifications to calculate the measures. Some states calculated Health Home Core Set measures using “other specifications.” Measures were denoted as using “other specifications” when the state deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

AIDS = Acquired Immunodeficiency Syndrome; CEDARR = Comprehensive Evaluation, Diagnosis, Assessment, Referral & Reevaluation; HIV = Human Immunodeficiency Virus; I/DD = Intellectual/Developmental Disabilities; MAT = Medication Assisted Treatment

Number of Health Home Core Set Measures Reported for Health Home Programs, FFY 2018–FFY 2020

Health Home Program	FFY 2020	FFY 2019	FFY 2018
Connecticut Serious and Persistent Mental Illness	12	10	10
Dist. of Col. Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	12	0	8
Dist. of Col. Chronic Conditions	12	7	4
Maryland Health Home Services	12	10	8
Oklahoma Health Home (Adults)	12	9 1 10	9
South Dakota Health Home	12	10	10
Missouri Community Mental Health Center Health Home	11	9	9
Missouri Primary Care Clinic Health Home	11	9	9
Iowa Severe and Persistent Mental Illness Health Home	10	8	7 1 8
West Virginia Health Homes for Individuals with Chronic Conditions	9 1 10	6 1 7	6 1 7
Wisconsin Individuals with HIV/AIDS	10	10	10
Iowa Health Home Services	9	8	7 1 8
Maine Behavioral Health Home	9	6 1 7	4 2 6
Maine Health Home for Beneficiaries Receiving MAT for Opioid Addiction	9	4	NA
Maine Stage A Health Home Targeting Individuals with Chronic Conditions	9	6 1 7	4 2 6
Michigan Care Team	9	8	7
Michigan Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	9	8	8

0 2 4 6 8 10 12

Number of Measures Reported

FFY 2020 - Measure calculated using Core Set Specifications
FFY 2019 - Measure calculated using Core Set Specifications
FFY 2018 - Measure calculated using Core Set Specifications
Measure calculated using other specifications

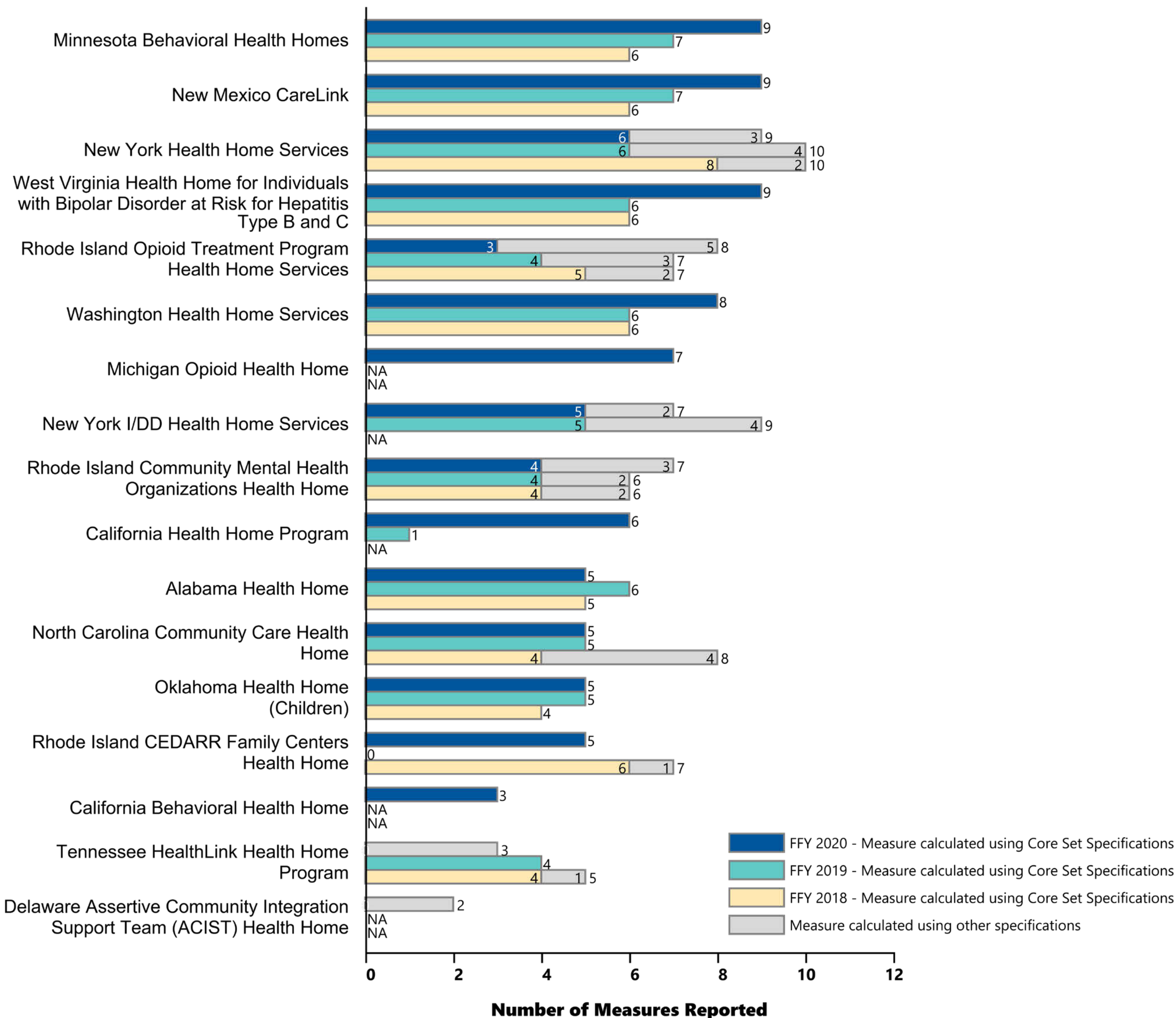
Chart is continued on the next slide.

Reporting remained consistent or increased for

24

of the 26 approved health home programs that reported for all three years from FFY 2018 to FFY 2020

Number of Health Home Core Set Measures Reported for Health Home Programs, FFY 2018–FFY 2020 (continued)



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021. FFY 2018 data reflect reporting as of September 13, 2019; FFY 2019 data reflect reporting as of July 27, 2020.

Notes: NA = State was not expected to report for the health home for the period. For the purpose of this Chart Pack, “expected” is defined as those states meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period).

Unless otherwise specified, states used Health Home Core Set specifications to calculate the measures. Some states calculated Health Home Core Set measures using “other specifications.” Measures were denoted as using “other specifications” when the state deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

AIDS = Acquired Immunodeficiency Syndrome; CEDARR = Comprehensive Evaluation, Diagnosis, Assessment, Referral & Reevaluation; HIV = Human Immunodeficiency Virus; I/DD = Intellectual and Developmental Disabilities; MAT = Medication Assisted Treatment

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Number of Health Home Programs Reporting the Health Home Core Set Measures, FFY 2020

Measure	Measure calculated using Core Set specifications	Measure calculated using other specifications	Total
Ambulatory Care: Emergency Department (ED) Visits	30	1	31
Follow-Up After Hospitalization for Mental Illness	28	2	30
Inpatient Utilization	27	3	30
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment			27
Plan All-Cause Readmissions	24	2	26
PQI 92: Chronic Conditions Composite			25
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence			24
Admission to an Institution from the Community	18	4	22
Adult Body Mass Index Assessment	19	3	22
Use of Pharmacotherapy for Opioid Use Disorder			21
Controlling High Blood Pressure	13	1	14
Screening for Depression and Follow-Up Plan	10	3	13

Axis: 0, 10, 20, 30, 40

Number of Approved Health Home Programs

Legend: Measure calculated using Core Set specifications; Measure calculated using other specifications

10 of the 12 Health Home Core Set measures were reported for at least 20 approved health home programs for FFY 2020

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: The 2020 Health Home Core Set includes 9 quality measures and 3 utilization measures. This chart includes all Health Home Core Set measures that states reported for the FFY 2020 reporting cycle. Unless otherwise specified, states used Health Home Core Set specifications to calculate the measures. Some states calculated Health Home Core Set measures using "other specifications." Measures were denoted as using "other specifications" when the state deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

Number of Health Home Programs Reporting the Health Home Core Set Measures, FFY 2018–FFY 2020

Measure	FFY 2020 – Core Set Specifications	FFY 2020 – Other specifications	FFY 2020 – Total	FFY 2019 – Core Set Specifications	FFY 2019 – Other specifications	FFY 2019 – Total	FFY 2018 – Core Set Specifications	FFY 2018 – Other specifications	FFY 2018 – Total
Ambulatory Care: Emergency Department (ED) Visits	30	1	31	30	1	31	27	3	30
Follow-Up After Hospitalization for Mental Illness	28	2	30	22	3	25			28
Inpatient Utilization	27	3	30	24	3	27	25	3	28
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment			27	26	1	27			26
Plan All-Cause Readmissions	24	2	26	18	7	25	14	11	25
PQI 92: Chronic Conditions Composite			25	22	1	23			24
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence			24			NA			NA
Admission to an Institution from the Community	18	4	22	14	6	20			NA
Adult Body Mass Index Assessment	19	3	22			24			21
Use of Pharmacotherapy for Opioid Use Disorder			21			NA			NA
Controlling High Blood Pressure	13	1	14	14	1	15	11	1	12
Screening for Depression and Follow-Up Plan	10	3	13	8	4	12	6	3	9

FFY 2020 - Measure calculated using Core Set Specifications
FFY 2019 - Measure calculated using Core Set Specifications
FFY 2018 - Measure calculated using Core Set Specifications
Measure calculated using other specifications

0 5 10 15 20 25 30

Number of Approved Health Home Programs

Reporting increased from 2018 to 2020 for all **9** measures included in both the 2018 and 2020 Health Home Core Sets

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021. FFY 2018 data reflect reporting as of September 13, 2019; FFY 2019 data reflect reporting as of July 27, 2020.

Notes: NA = not applicable; measure not included in the Health Home Core Set for the reporting period. The number of health home programs expected to report varies across reporting cycles: 32 programs were expected to report for FFY 2018, 35 programs for FFY 2019, and 37 programs for FFY 2020. For the purpose of this Chart Pack, “expected” is defined as those states meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period).

Unless otherwise specified, states used Health Home Core Set specifications to calculate the measures. Some states calculated Health Home Core Set measures using “other specifications.” Measures were denoted as using “other specifications” when the state deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies. The identification of deviations from Core Set specifications has improved over time, so trends in the use of other specifications should be interpreted with caution.

Percentage of Health Home Programs Reporting Health Home Core Set Measures, FFY 2018–FFY 2020

Measure	FFY 2020 (37 HHs)	FFY 2019 (35 HHs)	FFY 2018 (32 HHs)
Ambulatory Care: Emergency Department (ED) Visits	84%	89%	94%
Follow-Up After Hospitalization for Mental Illness	81%	71%	88%
Inpatient Utilization	81%	77%	88%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	73%	77%	81%
Plan All-Cause Readmissions	70%	71%	78%
PQI 92: Chronic Conditions Composite	68%	66%	75%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	65%	NA	NA
Admission to an Institution from the Community	59%	57%	NA
Adult Body Mass Index Assessment	59%	69%	66%
Use of Pharmacotherapy for Opioid Use Disorder	57%	NA	NA
Controlling High Blood Pressure	38%	43%	38%
Screening for Depression and Follow-Up Plan	35%	34%	28%

Percentage of Health Home Programs Expected to Report (axis: 0, 20, 40, 60, 80, 100)

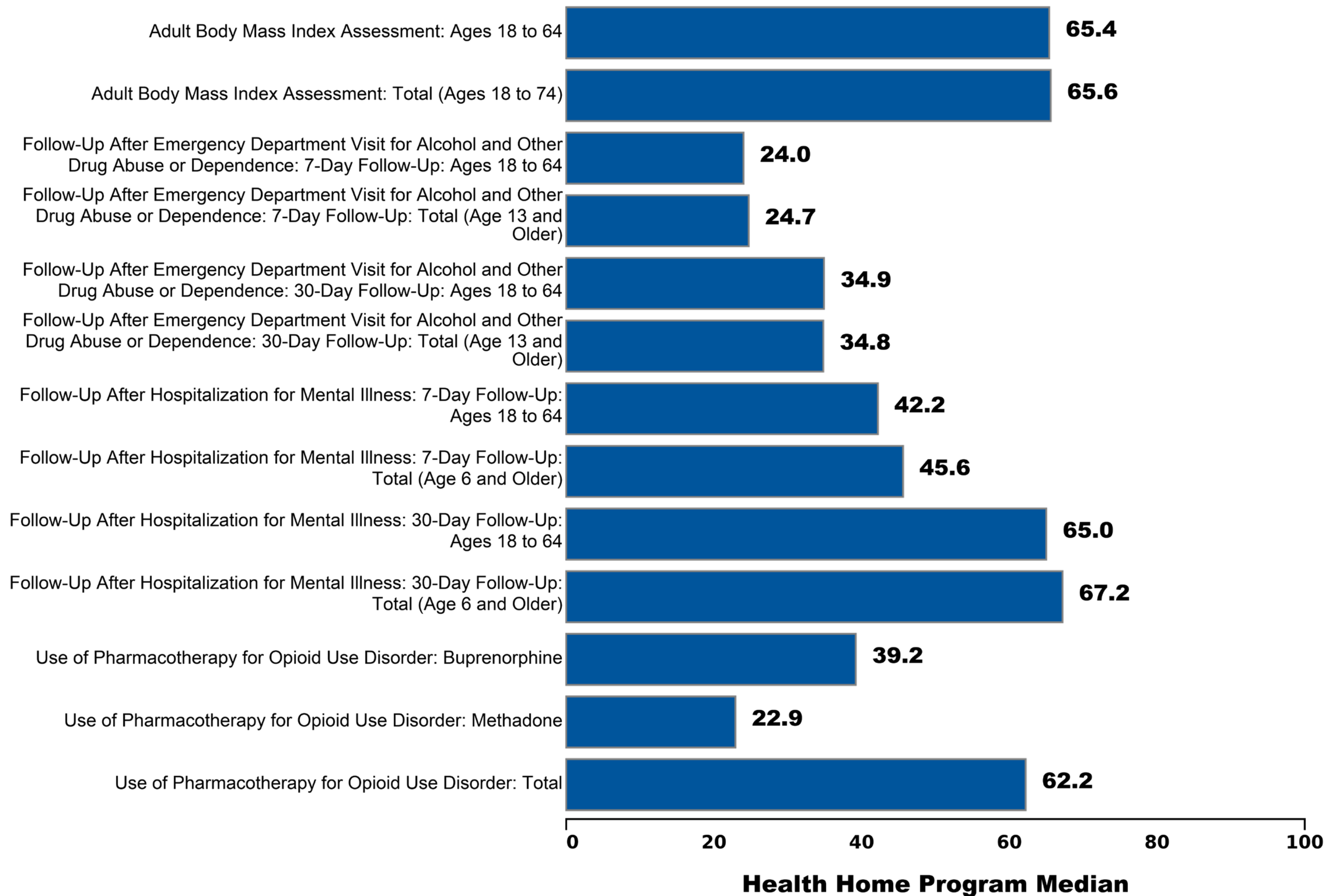
6 measures were reported by at least two-thirds of the approved health home programs that were expected to report in all three reporting years

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021. FFY 2018 data reflect reporting as of September 13, 2019; FFY 2019 data reflect reporting as of July 27, 2020.

Notes: For the purpose of this Chart Pack, “expected” is defined as those states meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period).

NA = not applicable; measure not included in the Health Home Core Set for the reporting period; HH = approved health home program.

Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020



All medians are reported as percentages except for Admission to an Institution from the Community, Ambulatory Care: Emergency Department (ED) Visits, and Inpatient Utilization, which are reported as rates per 1,000 enrollee months, and PQI 92: Chronic Conditions Composite, which is reported as a rate per 100,000 enrollee months.

Chart is continued on the next slide.

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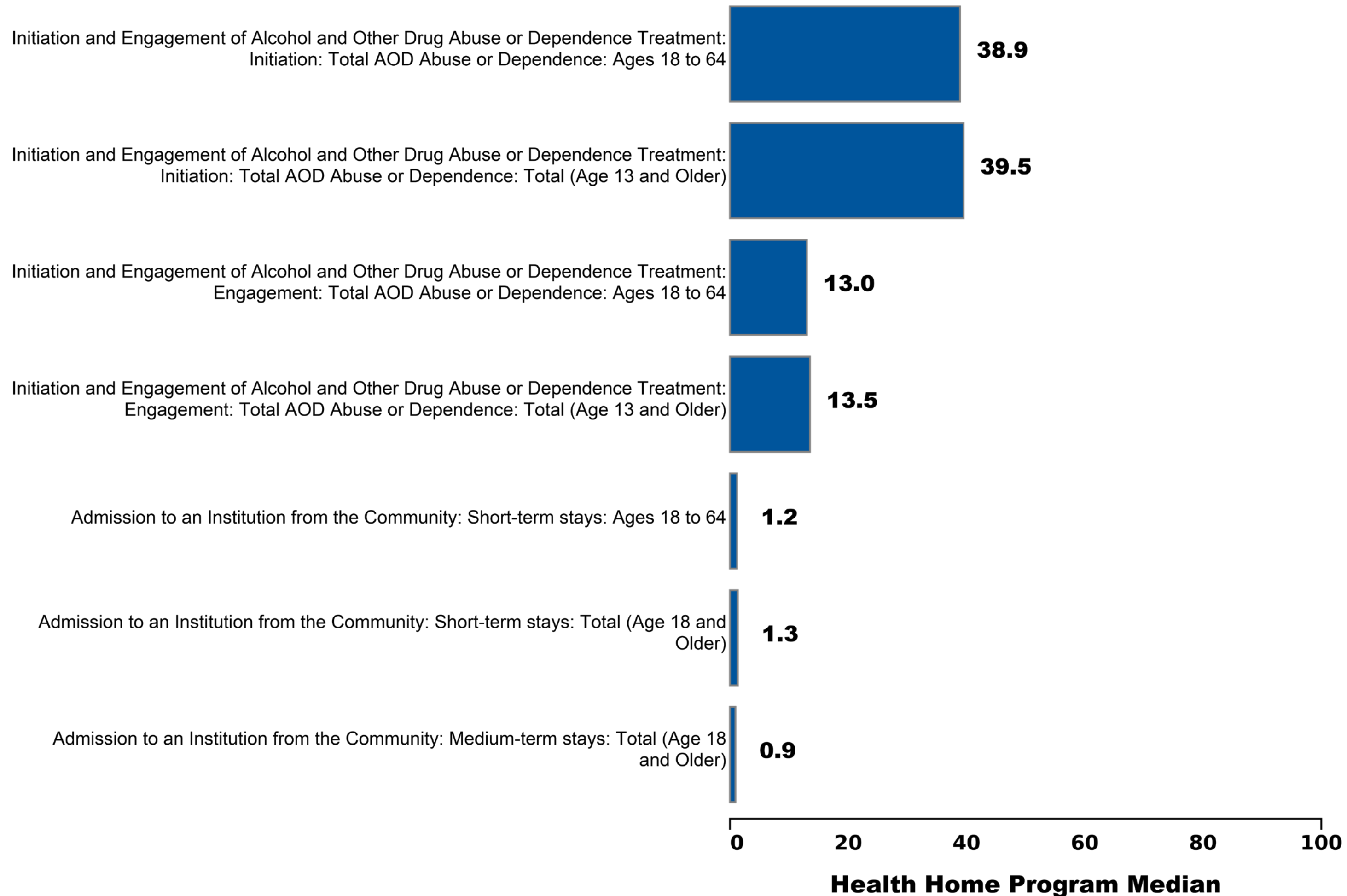
Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020 (continued)

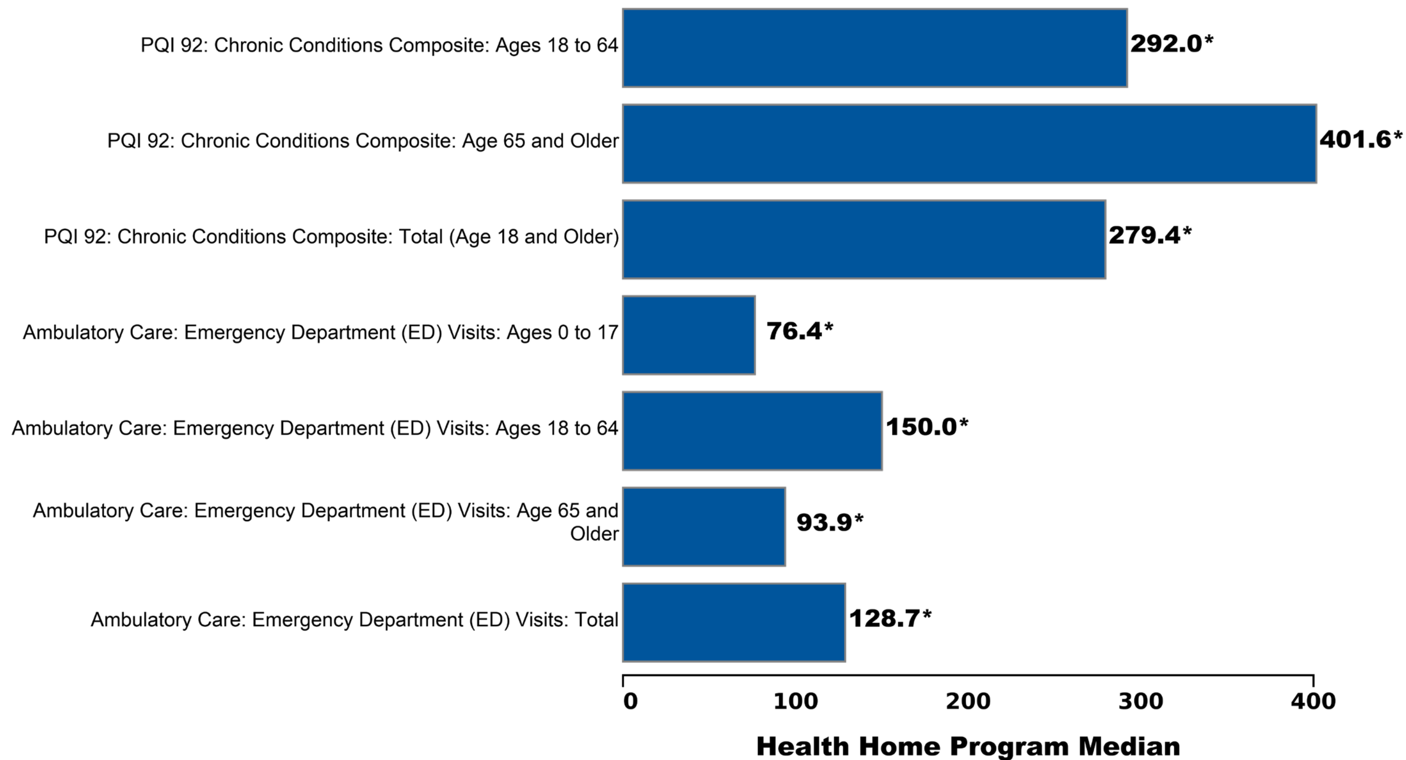


All medians are reported as percentages except for Admission to an Institution from the Community, Ambulatory Care: Emergency Department (ED) Visits, and Inpatient Utilization, which are reported as rates per 1,000 enrollee months, and PQI 92: Chronic Conditions Composite, which is reported as a rate per 100,000 enrollee months.

Chart is continued on the next slide.

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measures

Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020 (continued)



All medians are reported as percentages except for Admission to an Institution from the Community, Ambulatory Care: Emergency Department (ED) Visits, and Inpatient Utilization, which are reported as rates per 1,000 enrollee months, and PQI 92: Chronic Conditions Composite, which is reported as a rate per 100,000 enrollee months.

*Lower rates are better for this measure.

Chart is continued on the next slide.

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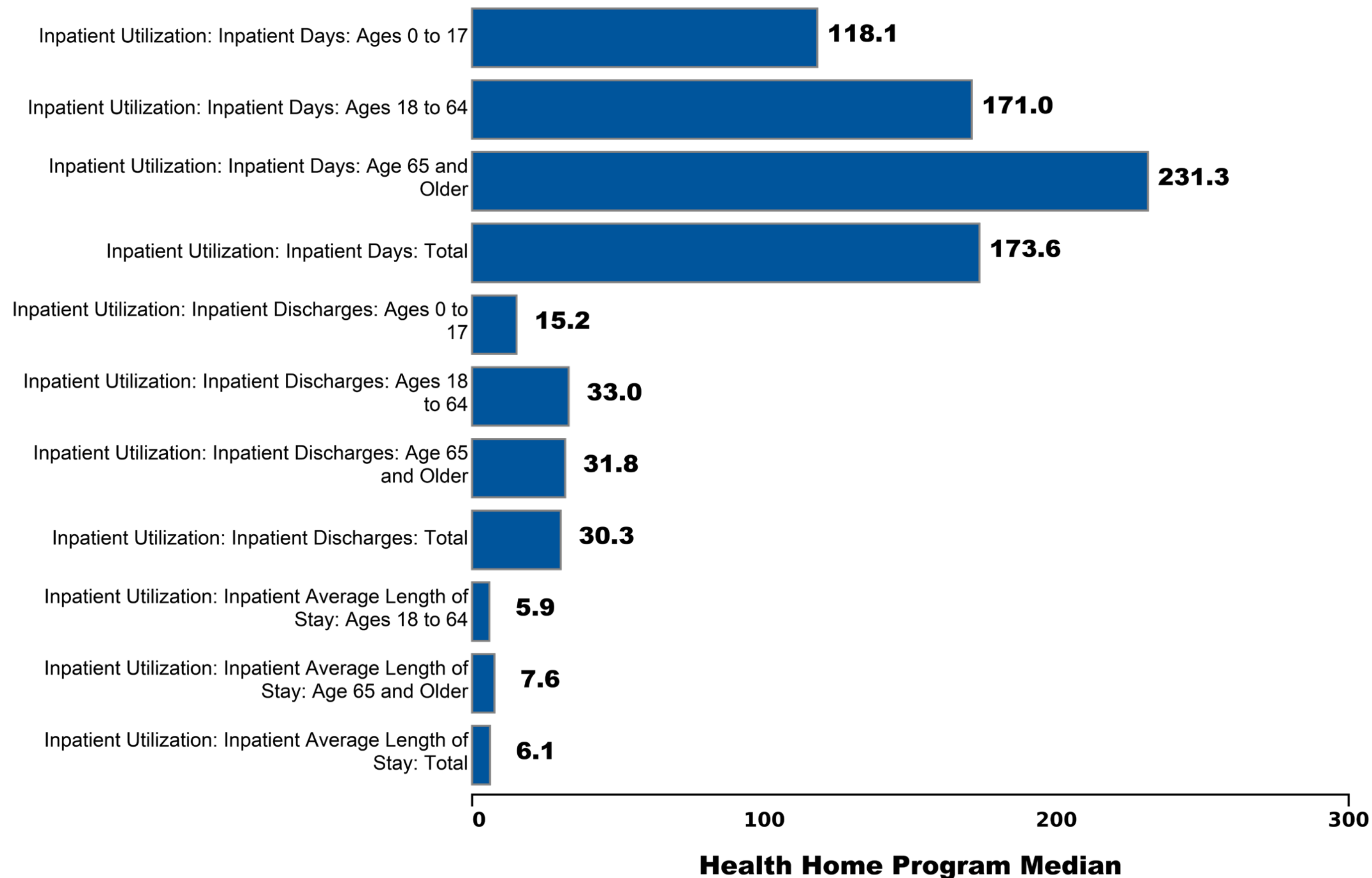
Health Care Quality Measures

Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020 (continued)



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Note: This chart includes measures that were reported by at least 15 approved health home programs for FFY 2020 and that met CMS standards for data quality. All medians are reported as percentages except for Admission to an Institution from the Community, Ambulatory Care: Emergency Department (ED) Visits, and Inpatient Utilization, which are reported as rates per 1,000 enrollee months, and PQI 92: Chronic Conditions Composite, which is reported as a rate per 100,000 enrollee months. This chart excludes the Plan All-Cause Readmissions measure, which uses a different summary statistic than those in this chart.

*Lower rates are better for this measure.

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Performance on the Health Home Core Set Measures, FFY 2020

Performance Data for Selected FFY 2020 Health Home Core Set Measures

Ten of the twelve Health Home Core Set measures were available for performance analysis for FFY 2020. For a measure to be available for analysis, data must be provided to CMS by at least 15 approved health home programs that used Core Set specifications, have a denominator of at least 30 enrollees, and meet CMS standards for data quality.[1]

Quality Measures

- Adult Body Mass Index Assessment
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Follow-Up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Use of Pharmacotherapy for Opioid Use Disorder
- Plan All-Cause Readmissions
- PQI 92: Chronic Conditions Composite

Utilization Measures

- Admission to an Institution from the Community
- Ambulatory Care: Emergency Department Visits
- Inpatient Utilization

[1] A methods brief describing the criteria for assessing performance and trends in performance on the Health Home Core Set measures is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

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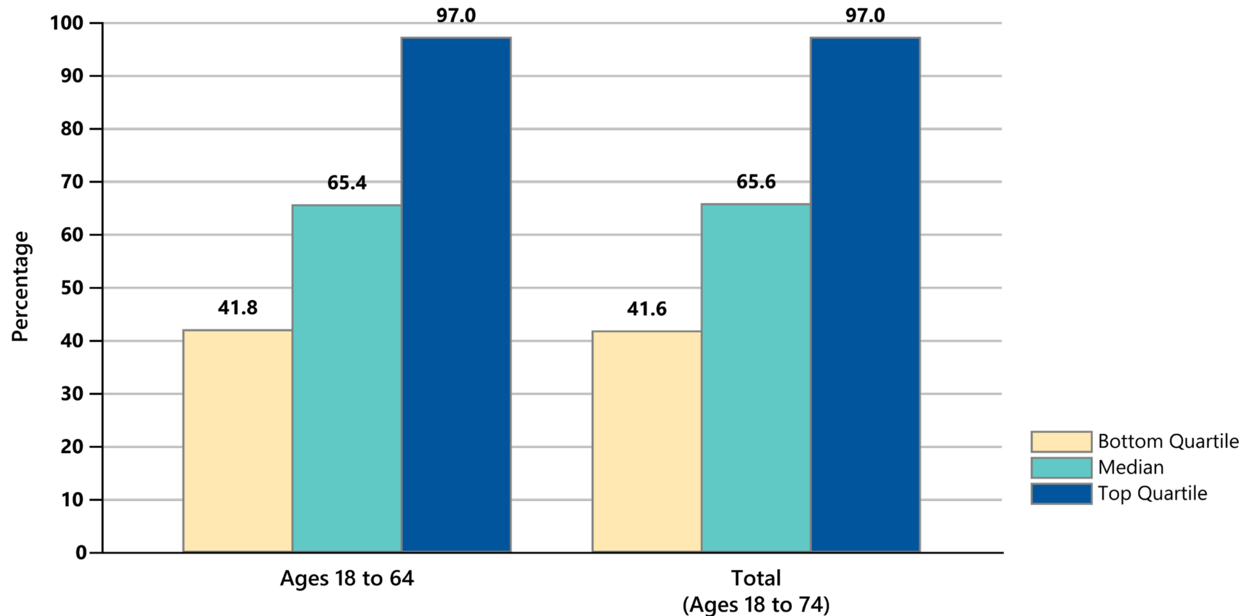
Adult Body Mass Index Assessment

Monitoring of body mass index (BMI) helps providers identify adults who are overweight or obese and at increased risk for related health complications. The Adult BMI Assessment measure shows the percentage of enrollees with an outpatient visit whose BMI value was documented in the medical record.

Percentage of Health Home Enrollees Ages 18 to 74 who had an Outpatient Visit and whose Body Mass Index Value was Documented in the Medical Record (ABA-HH), FFY 2020 (n = 18 HHs)



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

This measure shows the percentage of health home enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. This chart excludes RI's Community Mental Health Organizations, RI Opioid Treatment Program and the TN Health Link Health Home Program, which reported the measure but did not use Health Home Core Set specifications. The Ages 65 to 74 rate is not shown because fewer than 15 health home programs reported this rate for FFY 2020. Data were suppressed for the following health home programs due to small cell sizes: RI CEDARR Family Centers Health Home.

A median of

66

percent of health home enrollees ages 18 to 74 with an outpatient visit had their BMI value documented in the medical record (18 HHs)

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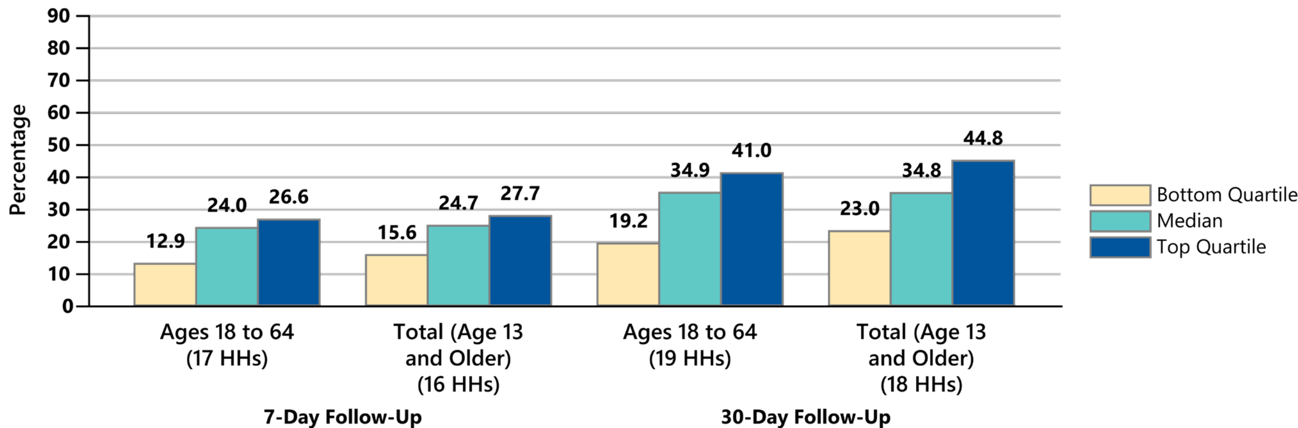
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Timely follow-up care after an emergency department (ED) visit for alcohol or other drug (AOD) abuse or dependence may reduce repeat ED visits, prevent hospital admissions, and improve health outcomes. The period immediately after the ED visit is important for engaging individuals in substance use treatment and establishing continuity of care. This measure shows the percentage of health home enrollees who had a follow-up visit with any practitioner within 7 and 30 days of an ED visit for AOD abuse or dependence. Performance on this measure is being publicly reported for the first time for FFY 2020.

Percentage of Emergency Department (ED) Visits for Health Home Enrollees Age 13 and Older with a Principal Diagnosis of Alcohol or Other Drug (AOD) Abuse or Dependence with a Follow-Up Visit within 7 and 30 Days After the ED Visit (FUA-HH), FFY 2020



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

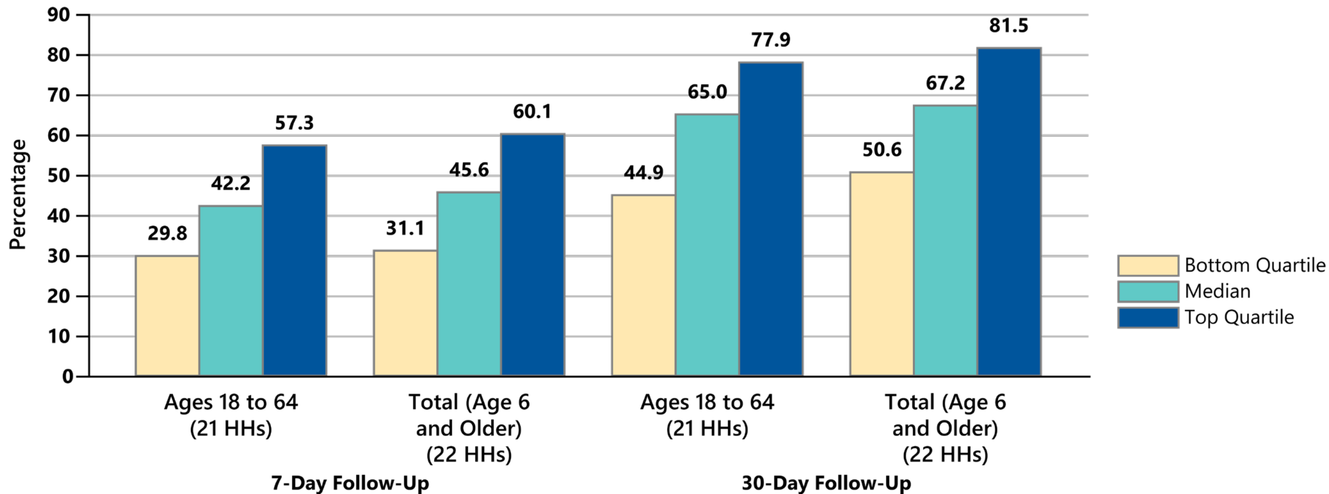
This measure shows the percentage of emergency department (ED) visits for health home enrollees age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence that had a follow-up visit for AOD abuse or dependence. Two rates are reported: (1) the percentage of ED visits for which the beneficiary had a follow-up visit for AOD abuse or dependence within 7 days of the ED visit; and (2) the percentage of ED visits for which the beneficiary had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit. Rates for Ages 13 to 17 and Age 65 and Older are not shown because fewer than 15 health home programs reported these rates for FFY 2020. Data were suppressed for the following health home programs due to small cell sizes: CA Behavioral Health Home, DC Chronic Conditions for Total (Age 13 and Older), IA Health Home Services, MI Chronic Care Model, MI Opioid Health Home, NM CareLink for both 7-Day Follow-Up rates, SD Health Home, and WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for both 7-Day Follow-Up rates.

A median of **25** percent of ED visits for health home enrollees age 13 and older with a diagnosis of AOD abuse or dependence had a follow-up visit within 7 days (16 HHs) and **35** percent had a follow-up visit within 30 days (18 HHs)

Follow-Up After Hospitalization for Mental Illness

Follow-up care after hospitalization for mental illness or intentional self harm helps improve health outcomes and prevent readmissions in the days following discharge from inpatient mental health treatment. Recommended post-discharge treatment includes a visit with an outpatient mental health practitioner within 30 days of discharge and ideally, within 7 days of discharge.

Percentage of Discharges for Health Home Enrollees Age 6 and Older Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit with a Mental Health Practitioner within 7 and 30 Days After Discharge (FUH-HH), FFY 2020



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

This measure shows the percentage of discharges for health home enrollees age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner. Two rates are reported: (1) the percentage of discharges for which the beneficiary received follow-up within 7 days after discharge; and (2) the percentage of discharges for which the beneficiary received follow-up within 30 days after discharge. Rates for Ages 6 to 17 and Age 65 and Older are not shown because fewer than 15 health home programs reported these rates for FFY 2020. This chart excludes the DE Assertive Community Integration Support Team (ACIST) Health Home and the TN Health Link Health Home Program, which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction, MI Chronic Care Model, Michigan Opioid Health Home, RI CEDARR Family Centers Health Home, WV Health Home for Individuals with Chronic Conditions, and WI Individuals with HIV/AIDS.

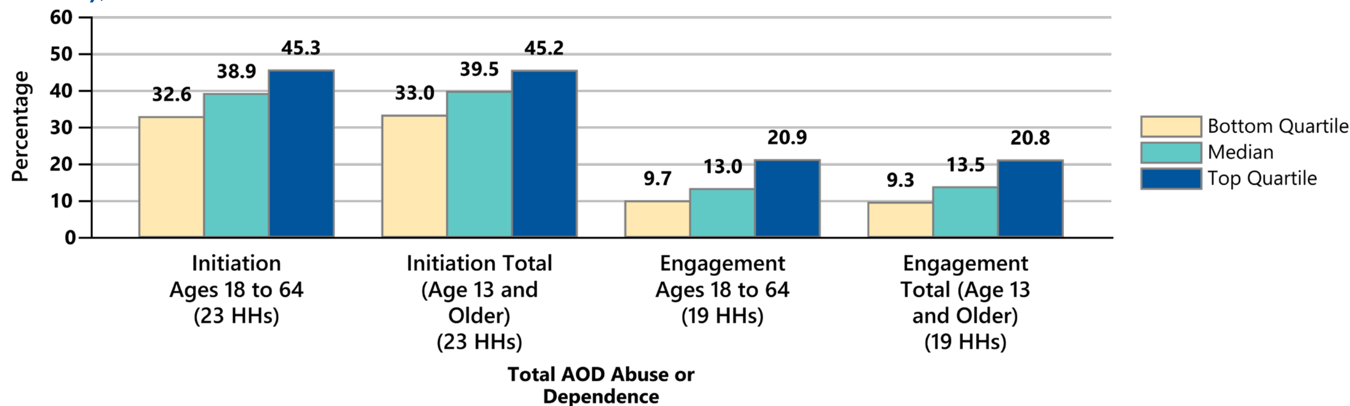
A median of **46** percent of health home enrollees age 6 and older who were hospitalized for mental illness or intentional self-harm had a follow-up visit within 7 days after discharge and **67** percent had a follow-up visit within 30 days after discharge (22 HHs)

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Treatment for alcohol or other drug (AOD) abuse or dependence can improve health, productivity, and social outcomes, and can save millions of dollars on health care and related costs. This measure shows how often enrollees with newly-diagnosed AOD dependence initiated timely treatment (within 14 days of diagnosis), and then continued that treatment (two or more additional services or medication treatment within 34 days of the initiation visit).

A median of **40** percent of health home enrollees age 13 and older with alcohol or other drug abuse or dependence initiated treatment within 14 days of diagnosis (23 HHs)

Percentage of Health Home Enrollees Age 13 and Older with a New Episode of Alcohol or Other Drug Abuse or Dependence who: (1) Initiated Treatment within 14 Days of the Diagnosis and (2) Engaged in Ongoing Treatment within 34 Days of the Initiation Visit (IET-HH), FFY 2020



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

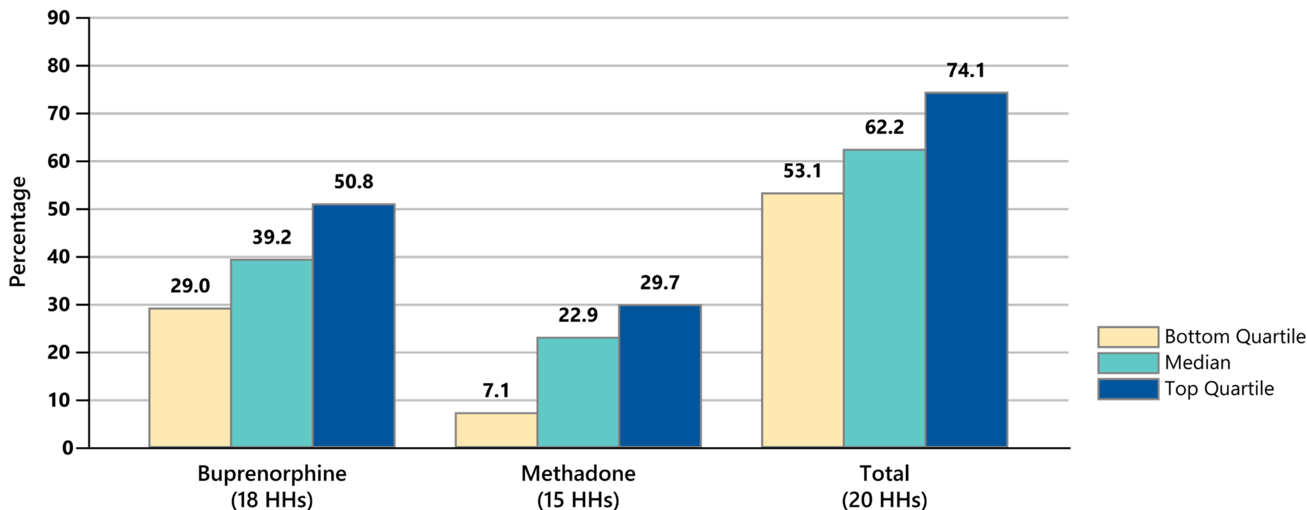
Notes: HH = approved health home program

This measure shows the percentage of health home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who: (1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis (initiation rate), and (2) initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit (engagement rate). Initiation rates for Alcohol Abuse or Dependence, Opioid Abuse or Dependence, and Other Drug Abuse or Dependence for Ages 18 to 64 met performance reporting criteria but are not shown on this slide. Rates for Ages 13 to 17, Age 65 and Older, and the engagement rates for Alcohol Abuse or Dependence, Opioid Abuse or Dependence, and Other Drug Abuse or Dependence for the Total (Age 13 and Older) age group, are not shown because fewer than 15 health home programs reported these rates for FFY 2020. Data were suppressed for the following health home programs due to small cell sizes: CA Health Home Program, IA Health Home Services, IA Severe and Persistent Mental Illness for the Total (Age 13 and Older) Engagement rate, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction, MI Chronic Care Model, MN Behavioral Health Homes for the Total (Age 13 and Older) Engagement rate, OK Health Home (Children), and SD Health Home for the Total (Age 13 and Older) Engagement rate.

Use of Pharmacotherapy for Opioid Use Disorder

Increasing the use of pharmacotherapy for individuals with opioid use disorder can improve quality of care and outcomes such as a reduction in inappropriate drug use and improvements in vocational skills and employment. This measure assesses the percentage of health home enrollees ages 18 to 64 with an opioid use disorder who filled a prescription or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Performance on this measure is being publicly reported for the first time for FFY 2020.

Percentage of Health Home Enrollees Ages 18 to 64 with an Opioid Use Disorder who Filled a Prescription for or were Administered or Dispensed an FDA-Approved Medication for the Disorder (OUD-HH), FFY 2020



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Note: HH = approved health home program

This measure shows the percentage of health home enrollees ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: (1) Buprenorphine; (2) Oral Naltrexone; (3) Long-acting Injectable Naltrexone; (4) Methadone; and (5) Total (overall). Rates for Oral Naltrexone and Long-acting Injectable Naltrexone are not shown because fewer than 15 health home programs reported these rates for FFY 2020. Data were suppressed for the following health home programs due to small cell sizes: CA Health Home Program for Buprenorphine and Methadone, MO Primary Care Clinic for Methadone, NY I/DD Health Home Services for Buprenorphine and Methadone, OK Health Home (Adults), SD Health Home for Methadone, and WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Methadone.

A median of

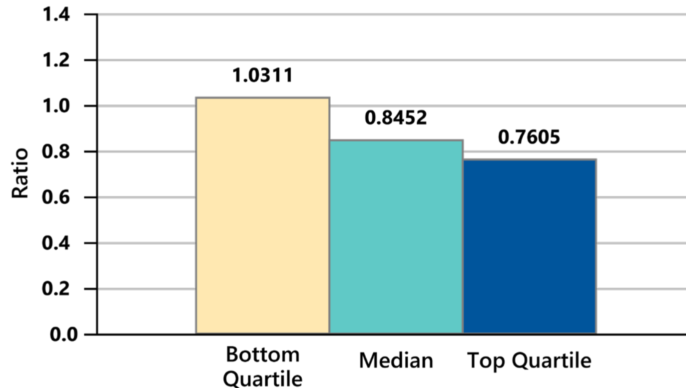
62

percent of health home enrollees ages 18 to 64 with an opioid use disorder filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year (20 HHs)

Plan All-Cause Readmissions

Unplanned readmissions to the hospital within 30 days of discharge are associated with adverse patient outcomes (including higher mortality) and higher health care costs. Readmissions may be prevented with coordination of care and support for patient self-management after discharge. This measure shows the ratio of observed readmissions to expected readmissions (O/E Ratio). The observed readmission rate is the number of acute inpatient stays during the measurement year for adults ages 18 to 64 that were followed by an unplanned acute readmission for any diagnosis within 30 days. This measure uses risk adjustment to calculate expected readmissions based on the characteristics of index hospital stays, including presence of surgeries, discharge condition, comorbidity, age, and gender.

Ratio of Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) among Health Home Enrollees Ages 18 to 64 (PCR-HH), FFY 2020 (n = 18 HHs) [Lower rates are better for this measure]



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Note: HH = approved health home program

The Observed/Expected (O/E) Ratio is calculated as the ratio of the observed to expected readmissions and is rounded to four decimal places. The O/E ratio is interpreted as "lower-is-better." An O/E ratio < 1.0 means there were fewer readmissions than expected given the case mix. An O/E ratio = 1 means that the number of readmissions was the same as expected given the case mix. An O/E ratio > 1.0 means that there were more readmissions than expected given the case mix. Specifications for this measure changed substantially for FFY 2020 and rates are not comparable with rates reported for previous years. This chart excludes RI's Community Mental Health Organizations and RI Opioid Treatment Program, which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: DC Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, ME Health Home for Beneficiaries Receiving Medication Assisted Treatment for Opioid Addiction, MI Chronic Care Model, Michigan Opioid Health Home, RI CEDARR Family Centers Health Home, and WI Individuals with HIV/AIDS.

Of the 18 approved health home programs reporting the measure,

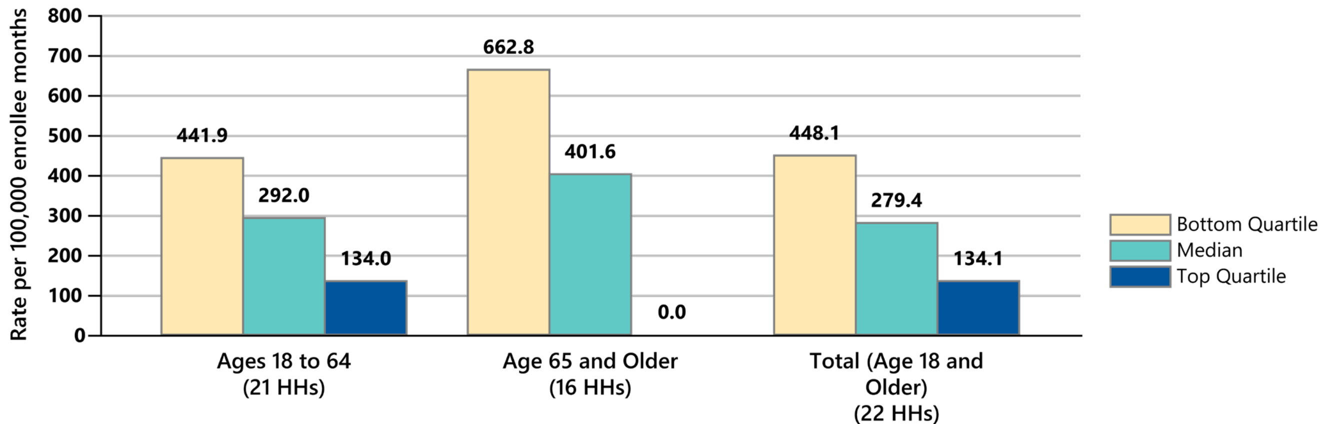
14

programs had fewer readmissions than expected given the case mix

PQI 92: Chronic Conditions Composite

In the absence of access to high quality outpatient care, chronic conditions can lead to complications that require inpatient hospital admissions, which are associated with adverse patient outcomes and higher health care costs. These admissions may be prevented with coordination of care and support for patient self-management. This measure assesses the frequency of inpatient hospital admissions to treat ambulatory care sensitive chronic conditions among adult health home enrollees.

Number of Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months for Health Home Enrollees Age 18 and Older (PQI92-HH), FFY 2020 [Lower rates are better for this measure]



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Note: HH = approved health home program

This measure shows the number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months for health home enrollees age 18 and older. The measure includes adult hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.

Data were suppressed for the following health home programs due to small cell sizes: AL Health Home for Age 65 and Older, CT Serious and Persistent Mental Illness for Age 65 and Older, DC Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions for Age 65 and Older, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MD Health Home Services for Age 65 and Older, MI Opioid Health Home for Ages 18 to 64 and Total, MN Behavioral Health Homes for Age 65 and Older, NM CareLink for Age 65 and Older, OK Health Home (Adults) for Ages 18 to 64 and Total, WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Ages 18 to 64 and Age 65 and Older, and WI Individuals with HIV/AIDS for Ages 18 to 64 and Total.

Health home enrollees age 18 and older had a median of

279

inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months (22 HHs)

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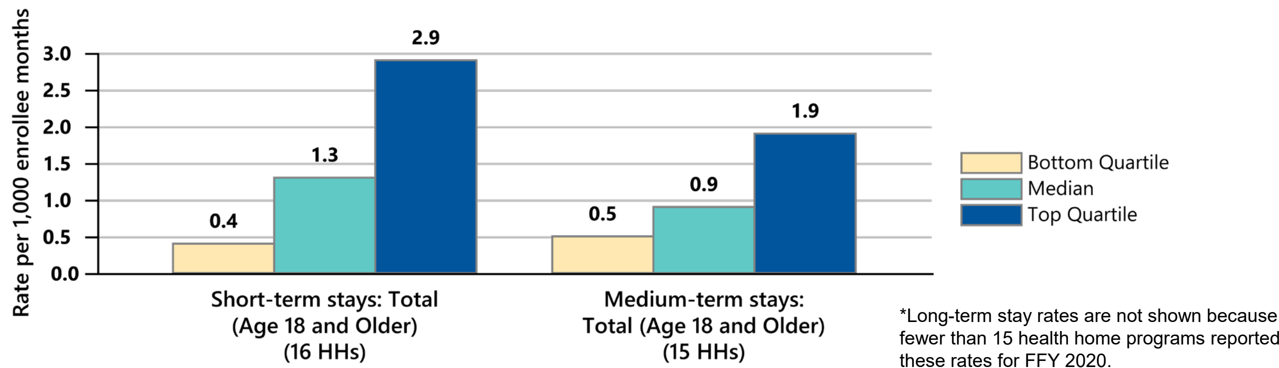
Admission to an Institution from the Community

The Medicaid health home program seeks to improve care management and outcomes for enrollees with chronic conditions, including appropriate use of institutions such as nursing facilities and intermediate care facilities. This measure shows the number of admissions to an institution among health home enrollees age 18 and older resident in the community for at least one month. Three rates are reported: short-term stays, medium-term stays, and long-term stays. Performance on this measure is being publicly reported for the first time for FFY 2020.

Number of Admissions to an Institution from the Community that Result in a Short-, Medium- or Long-Term* Stay per 1,000 Enrollee Months for Health Home Enrollees Age 18 and Older (AIF-HH), FFY 2020



*Long-term stay rates are not shown because fewer than 15 health home programs reported these rates for FFY 2020.

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

This measure shows the number of admissions to an institutional facility among health home enrollees age 18 and older residing in the community for at least one month. The number of short-, medium-, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month. Short-term stays are defined as 1 to 20 days; medium-term stays are defined as 21 to 100 days; and long-term stays are defined as greater than or equal to 101 days. The short-term stay rate for Ages 18 to 64 met performance reporting criteria but is not shown on this slide. Rates for Ages 65 to 74, Ages 75 to 84, and Age 85 and older, the medium- and long-term rates for Ages 18 to 64, and the total long-term rate for Age 18 and older are not shown because fewer than 15 health home programs reported these rates for FFY 2020. This chart excludes the NY Health Home Services and I/DD Health Home Services and the RI Community Mental Health Organizations Health Home and Opioid Treatment Program Health Home Services, which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: ME Behavioral Health Home for medium-term stays, ME Health Home for Individuals Receiving MAT for Opioid Addiction for short-term stays, MI Chronic Care Model for medium-term stays, and WI Individuals with HIV/AIDS.

Health home enrollees age 18 and older had a median of

1.3

short-term stays in an institutional facility per 1,000 enrollee months (16 HHs) and

0.9

medium-term stays in an institutional facility per 1,000 enrollee months (16 HHs)

Ambulatory Care: Emergency Department (ED) Visits

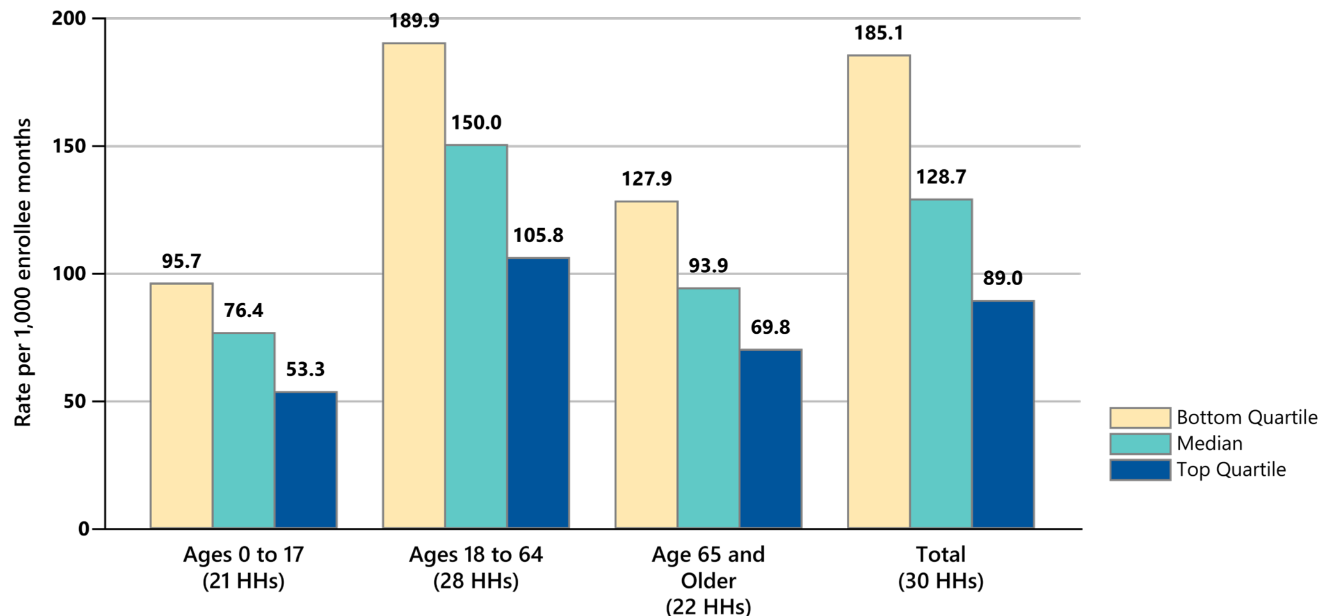
Unnecessary visits to a hospital emergency department (ED) may indicate lack of access to more appropriate sources of medical care, such as primary care providers or specialists. Excessive visits to the ED can result in overcrowding and increased ED wait time. Understanding the rate of ED visits among health home enrollees can help identify strategies to improve access to and utilization of appropriate sources of care.

Health home enrollees had a median of

129

emergency department visits per 1,000 enrollee months (30 HHs)

Rate of Emergency Department Visits per 1,000 Enrollee Months for Health Home Enrollees (AMB-HH), FFY 2020 [Lower rates are better for this measure]



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

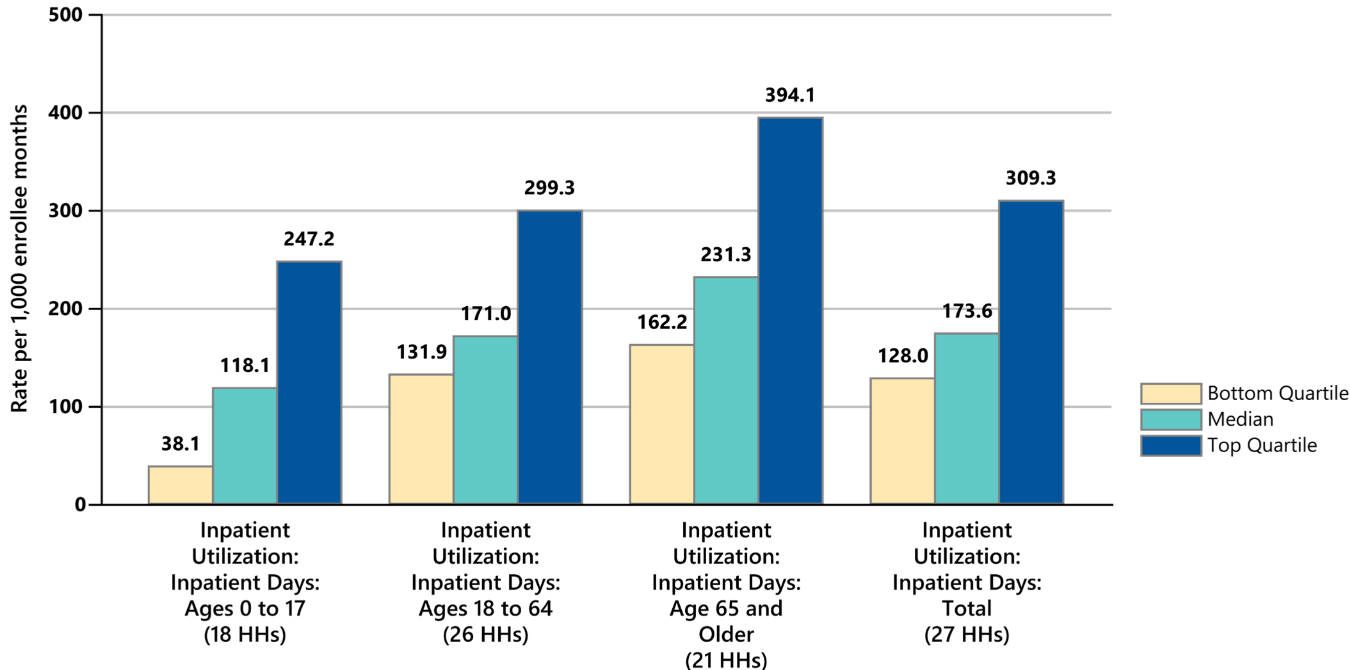
Notes: HH = approved health home program

This measure shows the rate of emergency department visits per 1,000 enrollee months among health home enrollees. This chart excludes the TN Health Link Health Home Program, which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MI Care Team for Age 65 and Older, NM CareLink for Age 65 and Older, RI CEDARR Family Centers for Ages 18 to 64, WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Ages 0 to 17, and WI Individuals with HIV/AIDS for Ages 0 to 17.

Inpatient Utilization: Inpatient Days

This measure shows the rate of inpatient days and discharges per 1,000 health home enrollee months, and average length of stay for acute inpatient hospital stays related to maternity, mental and behavioral disorders, surgery, and medicine.

Days of Acute Inpatient Care and Services per 1,000 Enrollee Months for Health Home Enrollees (IU-HH), FFY 2020



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

This measure shows the rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months among health home enrollees. This chart excludes the DE Assertive Community Integration Support Team (ACIST) Health Home, NY Health Home Services, and NY I/DD Health Home Services, which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MI Care Team for Ages 0 to 17, NM CareLink for Age 65 and Older, and WI Individuals with HIV/AIDS for Ages 0 to 17 and Age 65 and Older.

Health home enrollees spent a median of

174

days in the hospital per 1,000 enrollee months (27 HHs)

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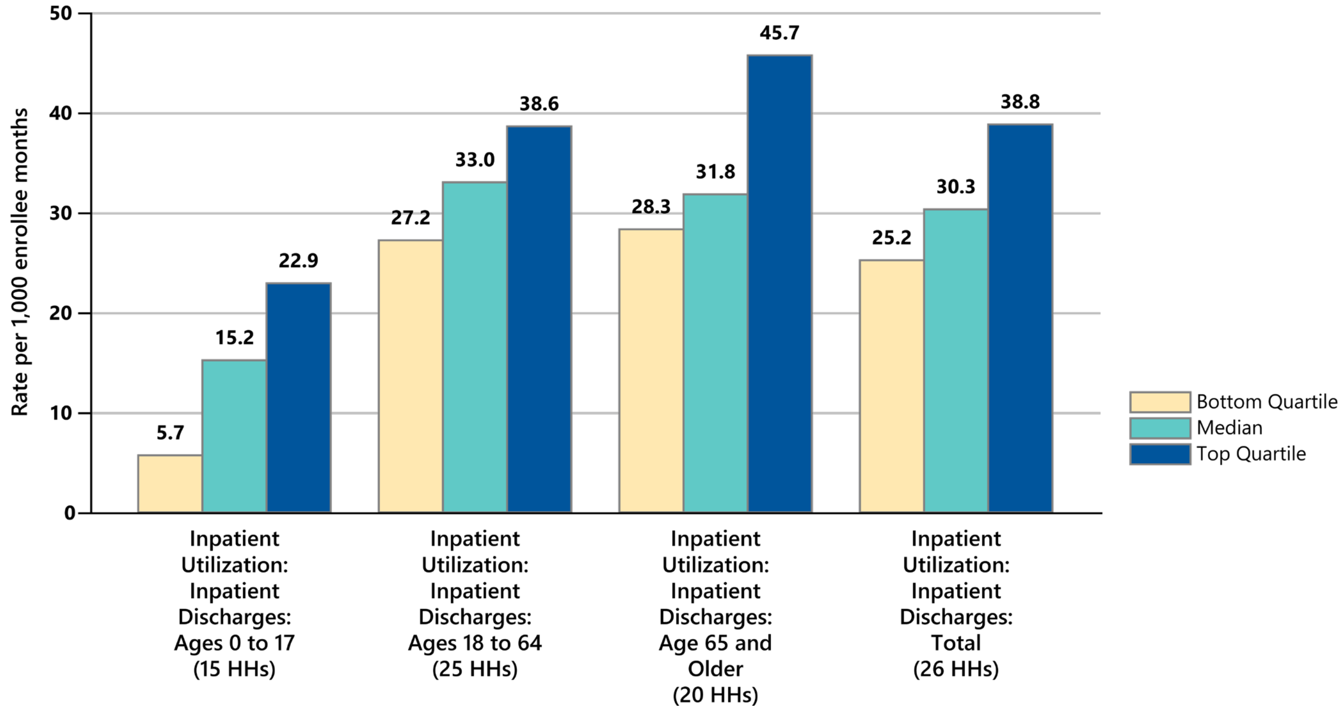
Inpatient Utilization: Inpatient Discharges (continued)

Discharges from Acute Inpatient Care and Services per 1,000 Enrollee Months for Health Home Enrollees (IU-HH), FFY 2020



Health Home enrollees had a median of

30

inpatient hospital discharges per 1,000 enrollee months (26 HHs)

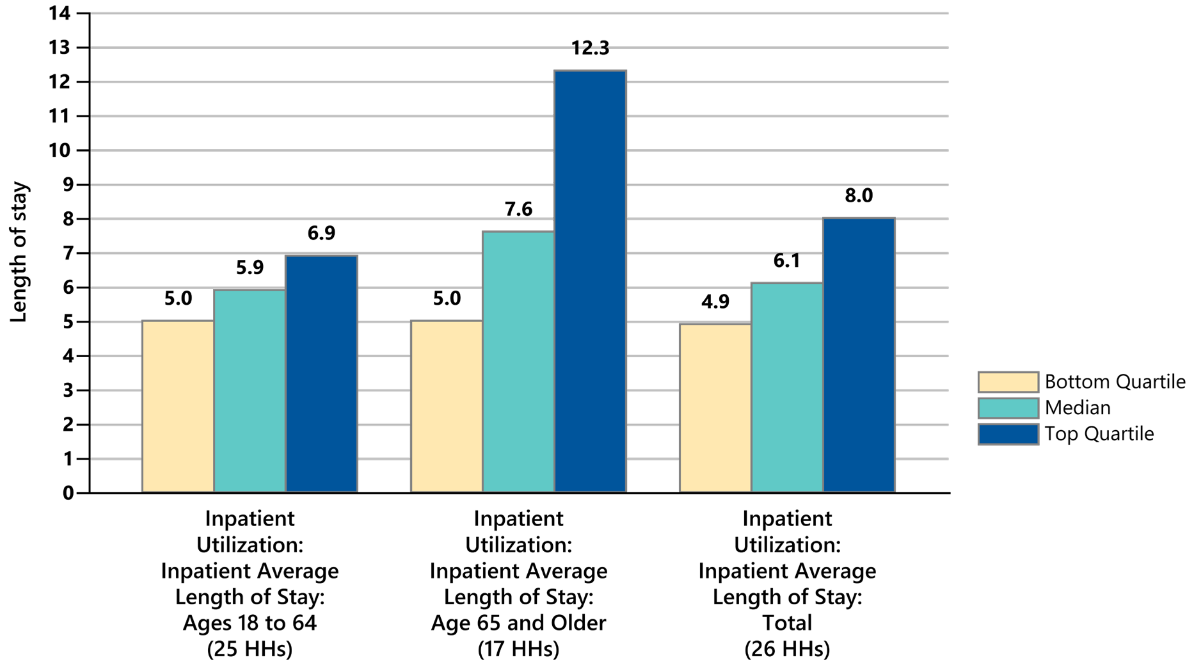
Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

This measure shows the rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months among health home enrollees. This chart excludes the DE Assertive Community Integration Support Team (ACIST) Health Home, NY Health Home Services, and NY I/DD Health Home Services which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: CA Behavioral Health Home for Ages 0 to 17 and Age 65 and Older, CT Serious and Persistent Mental Illness for Ages 0 to 17, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MI Care Team for Ages 0 to 17, MI Chronic Care Model for Ages 18 to 64 and Total, NM CareLink for Age 65 and Older, WV Health Home for Individuals with Bipolar Disorder at Risk of Hepatitis Type B and C for Ages 0 to 17, and WI Individuals with HIV/AIDS for Ages 0 to 17 and Age 65 and Older.

Inpatient Utilization: Inpatient Length of Stay (continued)

Average Length of Stay of Acute Inpatient Care and Services for Health Home Enrollees (IU-HH), FFY 2020



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: HH = approved health home program

This measure shows the rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months among health home enrollees. The denominator for length of stay is total discharges. Rates for Ages 0 to 17 are not shown because fewer than 15 health home programs reported these rates for FFY 2020. This chart excludes the DE Assertive Community Integration Support Team (ACIST) Health Home, NY Health Home Services, and NY I/DD Health Home Services, which reported the measure but did not use Health Home Core Set specifications. Data were suppressed for the following health home programs due to small cell sizes: DC Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions for Age 65 and Older, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MI Chronic Care Model for Ages 18 to 64 and Total, NM CareLink for Age 65 and Older, RI Opioid Treatment Program for Age 65 and Older, WV Health Home for Individuals with Bipolar Disorder at Risk of Hepatitis Type B and C for Age 65 and Older, WV Health Home for Individuals with Chronic Conditions and WI Individuals with HIV/AIDS for Age 65 and Older.

The median length of hospital stays for health home enrollees was

6

days per discharge (26 HHs)

TRENDS IN PERFORMANCE, FFY 2018–FFY 2020

Trends in Performance, FFY 2018–FFY 2020: Introduction

CMS assessed trends in median state performance on four Health Home Core Set measures reported from FFY 2018 to FFY 2020.[1] Trends are presented for measures that meet the following criteria:

- The measure met the criteria for performance reporting in all three years. To meet performance reporting criteria, the measure must be reported by at least 15 approved health home programs using Core Set specifications, have a denominator of at least 30 enrollees, and meet CMS standards for data quality.
- The measure was reported by a set of at least 10 approved health home programs that used Core Set specifications and had a denominator of at least 30 enrollees and were not suppressed under the CMS cell-size suppression policy in all three years.
- The measure specifications were comparable for all three years (no specification changed occurred during the three-year period that would make results incomparable across years).

Many factors may affect changes in the performance rates reported by approved health home programs on the Health Home Core Set measures. While shifts in access and quality may account for some of the changes in performance over time, other factors noted by health home programs include changes in:

- The method and data used to calculate the measures
- The populations included in the measures (such as managed care versus fee-for-service)
- Other aspects of their health home program that could affect reporting (such as changes to program eligibility, or transitions in data systems or delivery systems)

[1] A methods brief describing the criteria for assessing performance and trends in performance on the Health Home Core Set measures is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/health-home-core-set-methods-brief-nov-2021.pdf. Statistical significance was determined using the Wilcoxon Signed-Rank test ($p<.05$).

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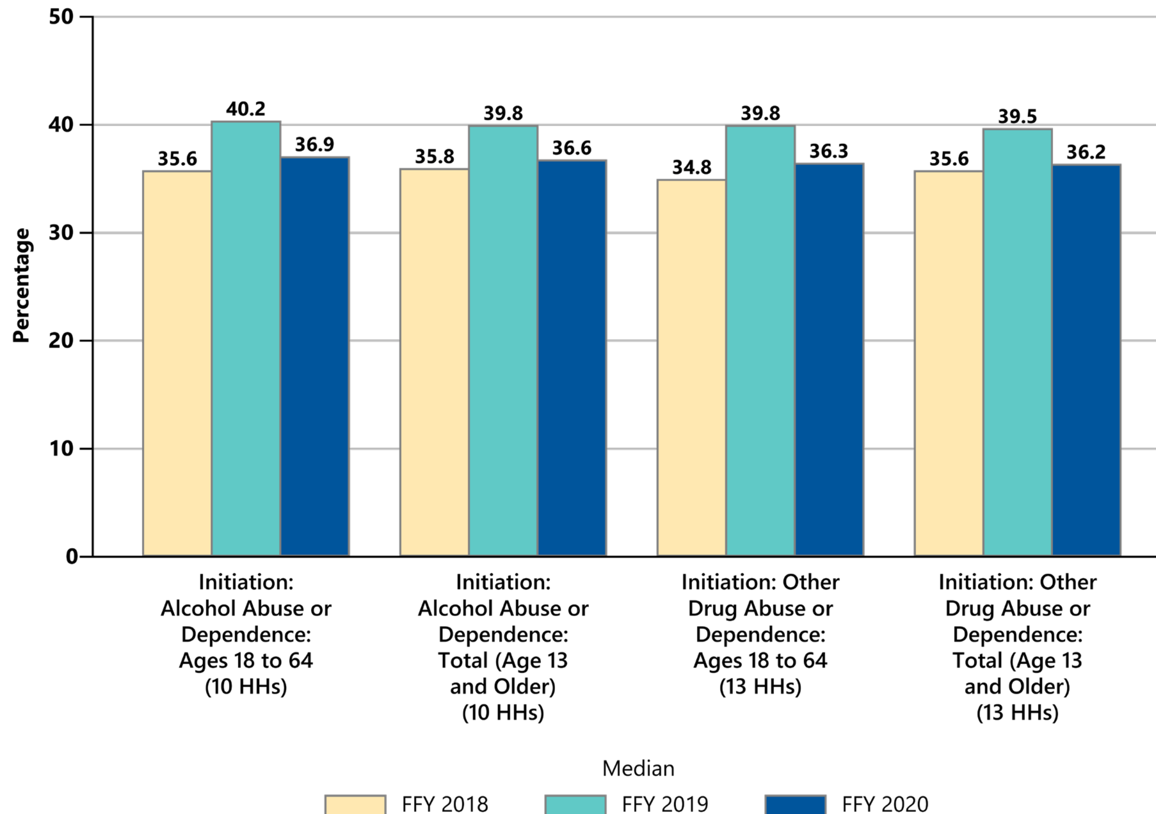
Trends in Performance, FFY 2018–2020: Initiation of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment: (1) Alcohol Abuse or Dependence and (2) Other Drug Abuse or Dependence

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the Initiation of AOD Abuse or Dependence Treatment (1) Alcohol Abuse or Dependence Initiation and (2) Other Drug Abuse or Dependence Initiation rates for all three years.



Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years. The Initiation rates for Ages 13 to 17 and Age 65 and Older and the Engagement rates for all age groups did not meet performance trending criteria and are not shown in this chart.

Trends in Performance, FFY 2018–2020: Initiation and Engagement of Alcohol and Other Drug Abuse (AOD) or Dependence Treatment: Total AOD Abuse or Dependence

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the Initiation and Engagement of AOD Abuse or Dependence Treatment: Total AOD rates for all three years.

Percentage

50
40
30
20
10
0

37.7
42.6
39.2
Initiation: Total AOD Abuse or Dependence: Ages 18 to 64 (17 HHs)

38.5
42.5
39.5
Initiation: Total AOD Abuse or Dependence: Total (Age 13 and Older) (17 HHs)

14.1
16.3
13.0
Engagement: Total AOD Abuse or Dependence: Ages 18 to 64 (13 HHs)

14.0
13.9
13.0
Engagement: Total AOD Abuse or Dependence: Total (Age 13 and Older) (13 HHs)

Median
FFY 2018
FFY 2019
FFY 2020

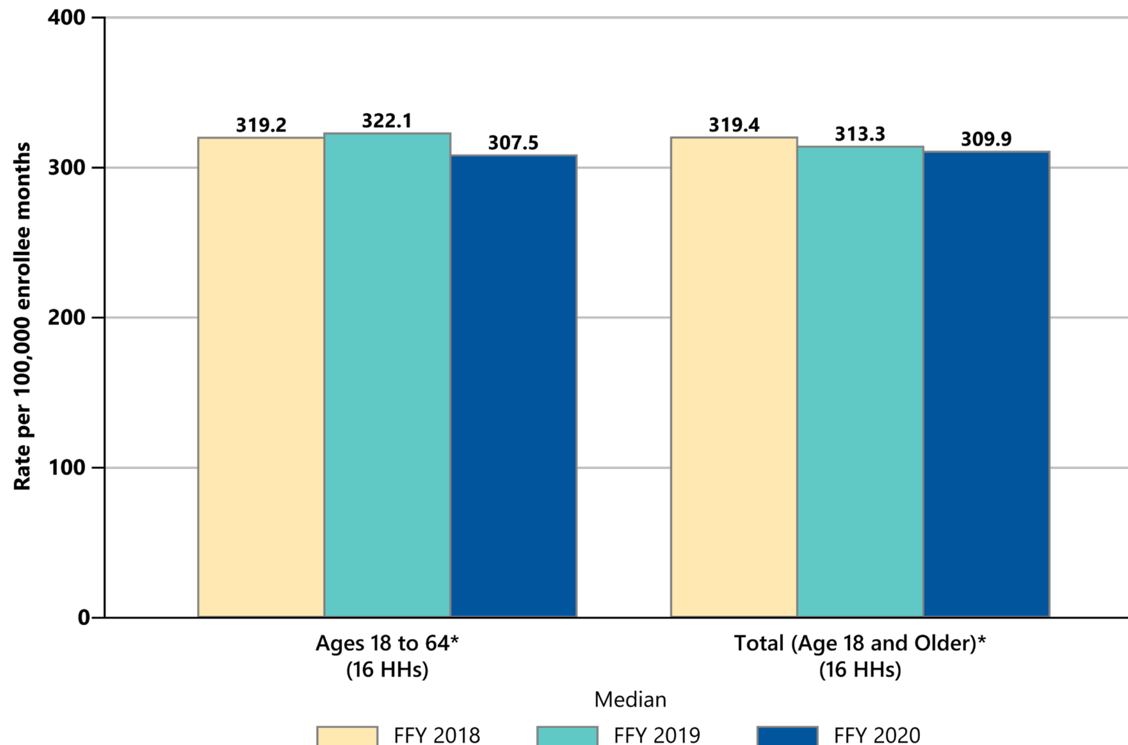
Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years. The Initiation and Engagement rates for Ages 13 to 17 and Age 65 and Older did not meet performance trending criteria and are not shown in this chart.

Trends in Performance, FFY 2018–2020: PQI 92: Chronic Conditions Composite

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the PQI 92: Chronic Conditions Composite measure for all three years.



Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years. The Age 65 and Older rate did not meet performance trending criteria and is not shown in this chart.

*Lower rates are better for this measure.

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Trends in Performance, FFY 2018–2020: Ambulatory Care: Emergency Department Visits

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the Ambulatory Care: Emergency Department Visits measure for all three years.

Median (Rate per 1,000 enrollee months)	FFY 2018	FFY 2019	FFY 2020
Ages 0 to 17* (15 HHs)	87.1	75.5	83.0
Ages 18 to 64* (20 HHs)	163.6	154.3	157.8
Age 65 and Older* (17 HHs)	96.0	85.7	83.5
Total* (21 HHs)	146.4	142.0	142.1

Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years.

*Lower rates are better for this measure.

Trends in Performance, FFY 2018–2020: Inpatient Utilization: Inpatient Days

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the rate of inpatient days per 1,000 health home enrollee months for all three years.

Rate per 1,000 enrollee months (Median)

Measure	FFY 2018	FFY 2019	FFY 2020
Inpatient Utilization: Inpatient Days: Ages 0 to 17 (11 HHs)	112.9	100.6	129.7
Inpatient Utilization: Inpatient Days: Ages 18 to 64 (18 HHs)	215.4	195.5	193.4
Inpatient Utilization: Inpatient Days: Age 65 and Older (11 HHs)	266.0	290.0	273.1
Inpatient Utilization: Inpatient Days: Total (19 HHs)	190.7	189.8	178.0

Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years.

Trends in Performance, FFY 2018–2020: Inpatient Utilization: Inpatient Discharges

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the rate of inpatient discharges per 1,000 health home enrollee months for all three years.

Rate per 1,000 enrollee months (Median)

Measure	FFY 2018	FFY 2019	FFY 2020
Inpatient Utilization: Inpatient Discharges: Ages 0 to 17 (11 HHs)	14.9	15.2	15.2
Inpatient Utilization: Inpatient Discharges: Ages 18 to 64 (17 HHs)	37.2	36.5	33.0
Inpatient Utilization: Inpatient Discharges: Age 65 and Older (11 HHs)	45.3	38.5	41.3
Inpatient Utilization: Inpatient Discharges: Total (18 HHs)	35.1	28.6	31.8

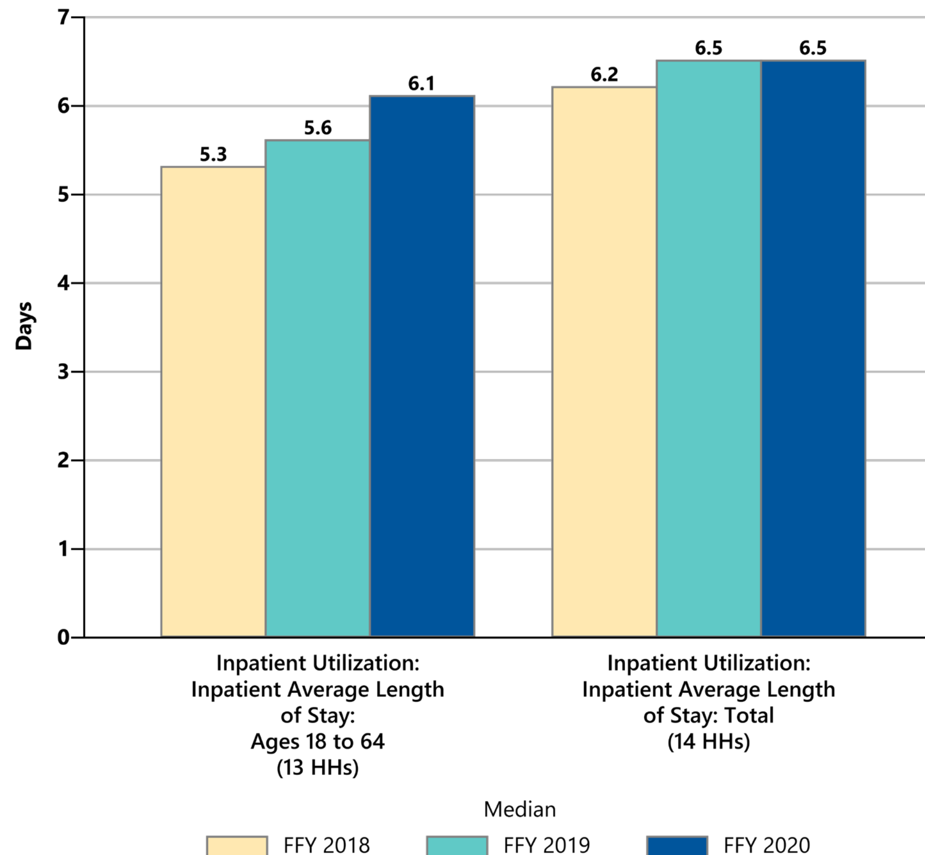
Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years.

Trends in Performance, FFY 2018–2020: Inpatient Utilization: Inpatient Length of Stay

Median performance did not change significantly between FFY 2018 and FFY 2020 among approved health home programs reporting the average length of inpatient stay for all three years.



Source: Mathematica analysis of FFY 2018-2020 MACPro reports.

Note: HH = approved health home program

This chart includes the approved health home programs that reported the measure using Health Home Core Set specifications for all three years. The Ages 0 to 17 and Age 65 and Older Inpatient Length of Stay rates did not meet the performance trending criteria for all three years and are not shown in this chart.

Centers for Medicare & Medicaid Services
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Health Care Quality Measures

REFERENCE TABLES AND ADDITIONAL RESOURCES

Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2020

	Number of Measures Reported	Adult Body Mass Index Assessment	Controlling High Blood Pressure	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Follow-Up After Hospitalization for Mental Illness	Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment	Use of Pharma-cotherapy for Opioid Use Disorder	Plan All-Cause Readmissions	PQI 92: Chronic Conditions Composite	Screening for Clinical Depression and Follow-Up Plan	Admission to an Institution from the Community	Ambulatory Care: Emergency Department Visits	Inpatient Utilization
Total	9 (Median)	22	14	24	30	27	21	26	25	13	22	31	30
Alabama Health Home	5	X	X	--	X	--	--	--	X	--	--	X	--
California Health Home Program	6	--	--	X	X	X	X	--	--	--	X	--	X
California Behavioral Health Home	3	--	--	X	--	--	--	--	--	--	X	--	X
Connecticut Serious and Persistent Mental Illness	12	X	X	X	X	X	X	X	X	X	X	X	X
Delaware Assertive Community Integration Support Team (ACIST) Health Home	2	--	--	--	X	--	--	--	--	--	--	--	X
Dist. of Col. Chronic Conditions	12	X	X	X	X	X	X	X	X	X	X	X	X
Dist. of Col. Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	12	X	X	X	X	X	X	X	X	X	X	X	X
Iowa Health Home Services	9	X	--	X	X	X	--	X	X	--	X	X	X
Iowa Severe and Persistent Mental Illness Health Home	10	X	--	X	X	X	--	X	X	X	X	X	X
Maine Behavioral Health Home	9	--	--	X	X	X	X	X	X	--	X	X	X
Maine Stage A Health Home Targeting Individuals with Chronic Conditions	9	--	--	X	X	X	X	X	X	--	X	X	X
Maine Health Home for Beneficiaries Receiving MAT for Opioid Addiction	9	--	--	X	X	X	X	X	X	--	X	X	X
Maryland Health Home Services	12	X	X	X	X	X	X	X	X	X	X	X	X
Michigan Care Team	9	X	--	X	X	X	--	X	X	--	X	X	X
Michigan Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	9	X	--	X	X	X	--	X	X	--	X	X	X

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Centers for Medicare & Medicaid Services
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Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2020 (continued)

	Number of Measures Reported	Adult Body Mass Index Assessment	Controlling High Blood Pressure	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Follow-Up After Hospitalization for Mental Illness	Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment	Use of Pharma-cotherapy for Opioid Use Disorder	Plan All-Cause Readmissions	PQI 92: Chronic Conditions Composite	Screening for Clinical Depression and Follow-Up Plan	Admission to an Institution from the Community	Ambulatory Care: Emergency Department Visits	Inpatient Utilization
Michigan Opioid Health Home	7	--	--	X	X	X	--	X	X	--	--	X	X
Minnesota Behavioral Health Homes	9	X	--	X	X	X	X	X	X	--	--	X	X
Missouri Community Mental Health Center Health Home	11	X	X	X	X	X	X	X	X	--	X	X	X
Missouri Primary Care Clinic Health Home	11	X	X	X	X	X	X	X	X	--	X	X	X
New Mexico CareLink	9	X	--	X	X	X	X	X	X	--	--	X	X
New York Health Home Services	9	--	--	X	X	X	X	--	X	X	X	X	X
New York I/DD Health Home Services	7	--	--	--	X	X	X	--	X	--	X	X	X
North Carolina Community Care Health Home	5	--	--	X	X	X	--	X	--	--	--	X	--
Oklahoma Health Home (Adults)	12	X	X	X	X	X	X	X	X	X	X	X	X
Oklahoma Health Home (Children)	5	--	--	--	X	X	--	--	--	X	--	X	X
Rhode Island CEDARR Family Centers Health Home	5	X	--	--	X	--	--	X	--	X	--	X	--
Rhode Island Community Mental Health Organizations Health Home	7	X	X	--	--	--	X	X	--	--	X	X	X
Rhode Island Opioid Treatment Program Health Home Services	8	X	X	--	--	--	X	X	--	X	X	X	X
South Dakota Health Home	12	X	X	X	X	X	X	X	X	X	X	X	X
Tennessee HealthLink Health Home Program	3	X	--	--	X	--	--	--	--	--	--	X	--

Table is continued on the next slide.

Centers for Medicare & Medicaid Services
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Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2020 (continued)

	Number of Measures Reported	Adult Body Mass Index Assessment	Controlling High Blood Pressure	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Follow-Up After Hospitalization for Mental Illness	Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment	Use of Pharma-cotherapy for Opioid Use Disorder	Plan All-Cause Readmissions	PQI 92: Chronic Conditions Composite	Screening for Clinical Depression and Follow-Up Plan	Admission to an Institution from the Community	Ambulatory Care: Emergency Department Visits	Inpatient Utilization
Washington Health Home Services	8	--	--	X	X	X	X	X	X	--	--	X	X
West Virginia Health Homes for Individuals with Chronic Conditions	10	X	X	--	X	X	X	X	X	X	--	X	X
West Virginia Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C	9	X	X	X	--	X	X	X	X	--	--	X	X
Wisconsin Individuals with HIV/AIDS	10	X	X	--	X	X	--	X	X	X	X	X	X

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: The 2020 Health Home Core Set includes 12 measures. The following approved health home programs did not report Health Home Core Set measures for FFY 2020: New Jersey Behavioral Health Home Adult and Children health home programs and Vermont Health Home for Beneficiaries Receiving MAT for Opioid Addiction.
X = measure was reported by the health home program; -- = measure was not reported by the health home program.

Centers for Medicare & Medicaid Services Medicaid & CHIP Health Care Quality Measures

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Quality Measures						
Adult Body Mass Index Assessment	Percentage who had an Outpatient Visit with a BMI Documented in the Medical Record: Ages 18 to 64	18	67.2	65.4	41.8	97.0
Adult Body Mass Index Assessment	Percentage who had an Outpatient Visit with a BMI Documented in the Medical Record: Total (Ages 18 to 74)	18	66.9	65.6	41.6	97.0
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64	17	23.2	24.0	12.9	26.6
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 7 Days of the ED Visit: Total (Age 13 and Older)	16	24.7	24.7	15.6	27.7
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64	19	33.9	34.9	19.2	41.0
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 30 Days of the ED Visit: Total (Age 13 and Older)	18	35.7	34.8	23.0	44.8
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of Discharge: Ages 18 to 64	21	43.1	42.2	29.8	57.3
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of Discharge: Total (Age 6 and Older)	22	45.0	45.6	31.1	60.1
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of Discharge: Ages 18 to 64	21	62.2	65.0	44.9	77.9
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of Discharge: Total (Age 6 and Older)	22	65.2	67.2	50.6	81.5

Table is continued on the next slide.

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020 (continued)

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Quality Measures (continued)						
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	23	40.1	38.9	32.6	45.3
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Total (Age 13 and Older)	23	40.1	39.5	33.0	45.2
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	19	17.9	13.0	9.7	20.9
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Total (Age 13 and Older)	19	17.9	13.5	9.3	20.8
Use of Pharmacotherapy for Opioid Use Disorder	Percentage of adults ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed buprenorphine during the measurement year	18	40.7	39.2	29.0	50.8
Use of Pharmacotherapy for Opioid Use Disorder	Percentage of adults ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed methadone during the measurement year	15	27.9	22.9	7.1	29.7
Use of Pharmacotherapy for Opioid Use Disorder	Percentage of adults ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year	20	61.0	62.2	53.1	74.1
Plan All-Cause Readmissions	Ratio of Observed All-Cause Readmissions to Expected Readmissions: Ages 18 to 64 [Lower rates are better]	18	0.8479	0.8452	1.0311	0.7605
PQI 92: Chronic Conditions Composite	Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months: Ages 18 to 64 [Lower rates are better]	21	301.8	292.0	441.9	134.0

Table is continued on the next slide.

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020 (continued)

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Quality Measures (continued)						
PQI 92: Chronic Conditions Composite	Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months: Age 65 and Older [Lower rates are better]	16	523.3	401.6	662.8	0.0
PQI 92: Chronic Conditions Composite	Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months: Total (Age 18 and Older) [Lower rates are better]	22	313.6	279.4	448.1	134.1
Utilization Measures						
Admission to an Institution from the Community	Short-Term Stays per 1,000 Enrollee Months: Total (Age 18 and Older)	16	4.0	1.3	0.4	2.9
Admission to an Institution from the Community	Medium-Term Stays per 1,000 Enrollee Months: Total (Age 18 and Older)	15	2.0	0.9	0.5	1.9
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Ages 0 to 17 [Lower rates are better]	21	77.9	76.4	95.7	53.3
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Ages 18 to 64 [Lower rates are better]	28	176.9	150.0	189.9	105.8
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Age 65 and older [Lower rates are better]	22	133.7	93.9	127.9	69.8
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Total (All Ages) [Lower rates are better]	30	150.2	128.7	185.1	89.0

Table is continued on the next slide.

Centers for Medicare & Medicaid Services Medicaid & CHIP Health Care Quality Measures

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2020 (continued)

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Utilization Measures (continued)						
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Ages 0 to 17	18	304.0	118.1	38.1	247.2
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Ages 18 to 64	26	202.3	171.0	131.9	299.3
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Age 65 and Older	21	346.4	231.3	162.2	394.1
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Total (All Ages)	27	208.8	173.6	128.0	309.3
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 0 to 17	15	22.8	15.2	5.7	22.9
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 18 to 64	25	33.9	33.0	27.2	38.6
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Age 65 and Older	20	36.2	31.8	28.3	45.7
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Total (All Ages)	26	36.5	30.3	25.2	38.8
Inpatient Utilization	Inpatient Average Length of Stay: Ages 18 to 64	25	6.0	5.9	5.0	6.9
Inpatient Utilization	Inpatient Average Length of Stay: Age 65 and Older	17	8.9	7.6	5.0	12.3
Inpatient Utilization	Inpatient Average Length of Stay: Total (All Ages)	26	6.4	6.1	4.9	8.0

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021.

Notes: This table includes measures that were reported by at least 15 approved health home programs for FFY 2020 and that met CMS standards for data quality. This table includes data for health home programs that indicated they used Health Home Core Set specifications to report the measures and excludes health home programs that indicated they used other specifications and those that did not report the measures for FFY 2020. Additionally, health home programs were excluded if their data was suppressed due to small cell sizes. Means are calculated as the unweighted average of all health home program rates.

Trends in Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2018–FFY 2020

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications FFY 2018–FFY 2020	FFY 2018 Median	FFY 2019 Median	FFY 2020 Median
Quality Measures					
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	10	35.6	40.2	36.9
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Total (Age 13 and Older)	10	35.8	39.8	36.6
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	13	34.8	39.8	36.3
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Total (Age 13 and Older)	13	35.6	39.5	36.2
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	17	37.7	42.6	39.2
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Total (Age 13 and Older)	17	38.5	42.5	39.5
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	13	14.1	16.3	13.0
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Total (Age 13 and Older)	13	14.0	13.9	13.0
PQI 92: Chronic Conditions Composite	Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months: Ages 18 to 64 [Lower rates are better]	16	319.2	322.1	307.5

Table is continued on the next slide.

Trends in Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2018–FFY 2020 (continued)

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications FFY 2018–FFY 2020	FFY 2018 Median	FFY 2019 Median	FFY 2020 Median
Utilization Measures					
PQI 92: Chronic Conditions Composite	Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months: Total (Age 18 and Older) [Lower rates are better]	16	319.4	313.3	309.9
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Ages 0 to 17 [Lower rates are better]	15	87.1	75.5	83.0
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Ages 18 to 64 [Lower rates are better]	20	163.6	154.3	157.8
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Age 65 and Older [Lower rates are better]	17	96.0	85.7	83.5
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Enrollee Months: Total (All Ages) [Lower rates are better]	21	146.4	142.0	142.1
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Ages 0 to 17	11	112.9	100.6	129.7
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Ages 18 to 64	18	215.4	195.5	193.4
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Age 65 and Older	11	266.0	290.0	273.1
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Total (All Ages)	19	190.7	189.8	178.0
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 0 to 17	11	14.9	15.2	15.2
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 18 to 64	17	37.2	36.5	33.0
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Age 65 and Older	11	45.3	38.5	41.3
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Total (All Ages)	18	35.1	28.6	31.8
Inpatient Utilization	Inpatient Average Length of Stay: Ages 18 to 64	13	5.3	5.6	6.1
Inpatient Utilization	Inpatient Average Length of Stay: Total (All Ages)	14	6.2	6.5	6.5

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of July 13, 2021. FFY 2018 data reflect state reporting as of September 13, 2019; FFY 2019 data reflect state reporting as of July 27, 2020.

Notes: This table includes measures that each met the following criteria: (1) the measure met the criteria for performance reporting in all three years; (2) the measure was reported by a set of at least 10 approved health home programs that used Core Set specifications in all three years; (3) the measure specifications were comparable for all three years.

Acronyms

AOD	Alcohol and Other Drug
AIDS	Acquired Immunodeficiency Disorder
BMI	Body Mass Index
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral & Reevaluation
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ED	Emergency Department
FDA	Food and Drug Administration
FFY	Federal Fiscal Year
HH	Approved health home program
HIV	Human Immunodeficiency Virus
I/DD	Intellectual/Developmental Disability
MACPro	Medicaid and CHIP Program System
MAT	Medication Assisted Treatment
O/E	Observed-to-Expected
OUD	Opioid use disorder
PQI	Prevention Quality Indicator
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SPA	State Plan Amendment
SUD	Substance Use Disorder

Additional Resources

Additional resources related to the Health Home Core Set are available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html

These resources include:

- Technical Specifications and Resource Manuals for the Health Home Core Set
- Technical assistance resources for states
- Other background information on the Health Home Core Set

For more information about the Health Home Core Set please contact MACQualityTA@cms.hhs.gov.

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