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Medicaid & CHIP
Health Care Quality Measures

Quality of Care for Children and Adults Enrolled in Medicaid Health Homes: Findings from the 2021 Health Home Core Set

Chart Pack

March 2024

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About the 2021 Health Home Core Set

Medicaid Health Home programs provide person-centered, team-based care coordination to more than one million Medicaid beneficiaries in the United States 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 March 2023, 19 States have 33 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]

8

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 and the District of Columbia, and all territories
[2] https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-mar-2023.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

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About the 2021 Health Home Core Set (continued)

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) 2021, which generally covers care delivered in calendar year 2020. For a measure to be publicly reported, data must be provided to CMS by at least 15 Health Home programs and meet CMS standards for data quality.[5] The Chart Pack includes a detailed analysis of Health Home program reporting on 11 publicly reported measures.

For most measures, the performance reflects services provided in calendar year 2020, which was during the COVID-19 pandemic. Due to substantial disruptions in health care during calendar year 2020, this Chart Pack does not compare performance reported by programs for FFY 2021 with performance reported for prior years.

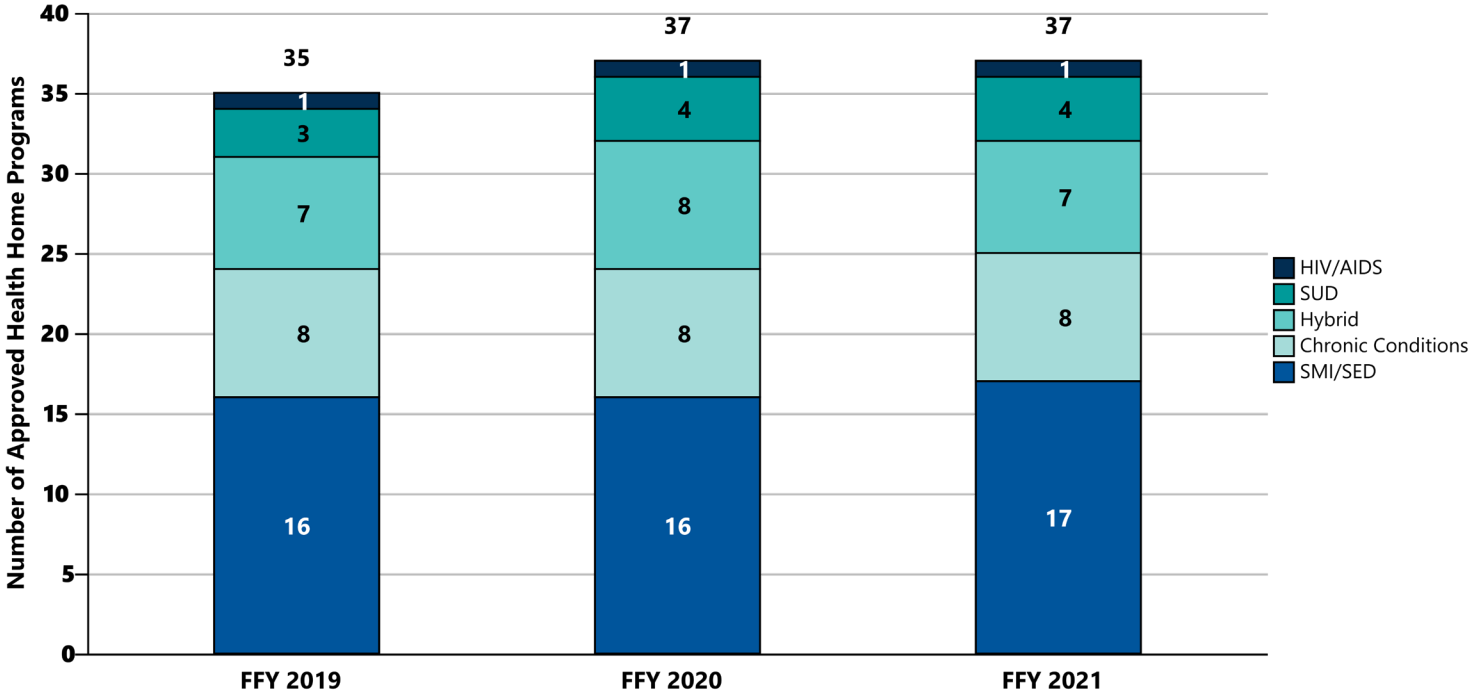
More information about the Health Home Core Set, including the measure performance tables, is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

[5] Performance data reported for publicly reported measures exclude Health Home programs that indicated they did not use Core Set specifications ("other specifications") or if they reported a denominator less than 30. Additionally, some rates were excluded because data cannot be displayed per the CMS cell-size suppression policy, which prohibits the direct reporting of data for enrollee and record counts of 1 to 10 and values from which users can derive values of 1 to 10

OVERVIEW OF REPORTING OF THE 2021 HEALTH HOME CORE SET BY APPROVED HEALTH HOME PROGRAMS

Number of Approved Health Home Programs by Target Conditions, FFY 2019–FFY 2021

Approved Health Home programs may focus on different conditions. In FFY 2021, 37 approved Health Home programs served beneficiaries with serious mental illness/severe emotional disturbance (SMI/SED), chronic medical conditions, substance use disorder (SUD), HIV/AIDS, or a combination of these conditions.



Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, March 2023.

Notes: 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.

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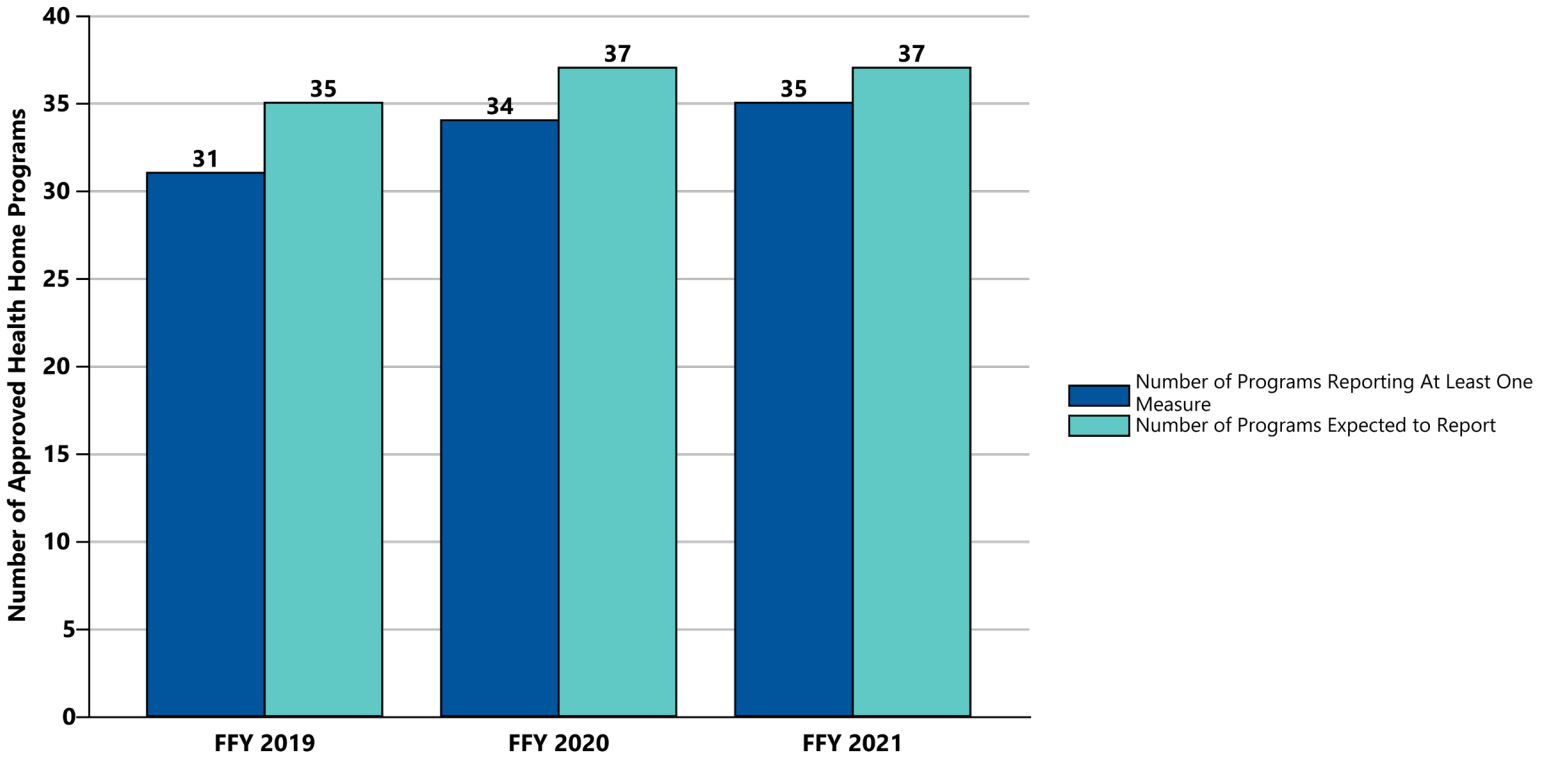
Summary of Health Home Core Set Reporting, FFY 2019–FFY 2021

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 2019 to FFY 2021, the number of programs reporting at least one Health Home Core Set measure has increased. Of the 37 approved Health Home programs expected* to report for FFY 2021, 35 reported at least one measure.



*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 FFY 2019 and 2020 MACPro reports and FFY 2021 QMR system reports.

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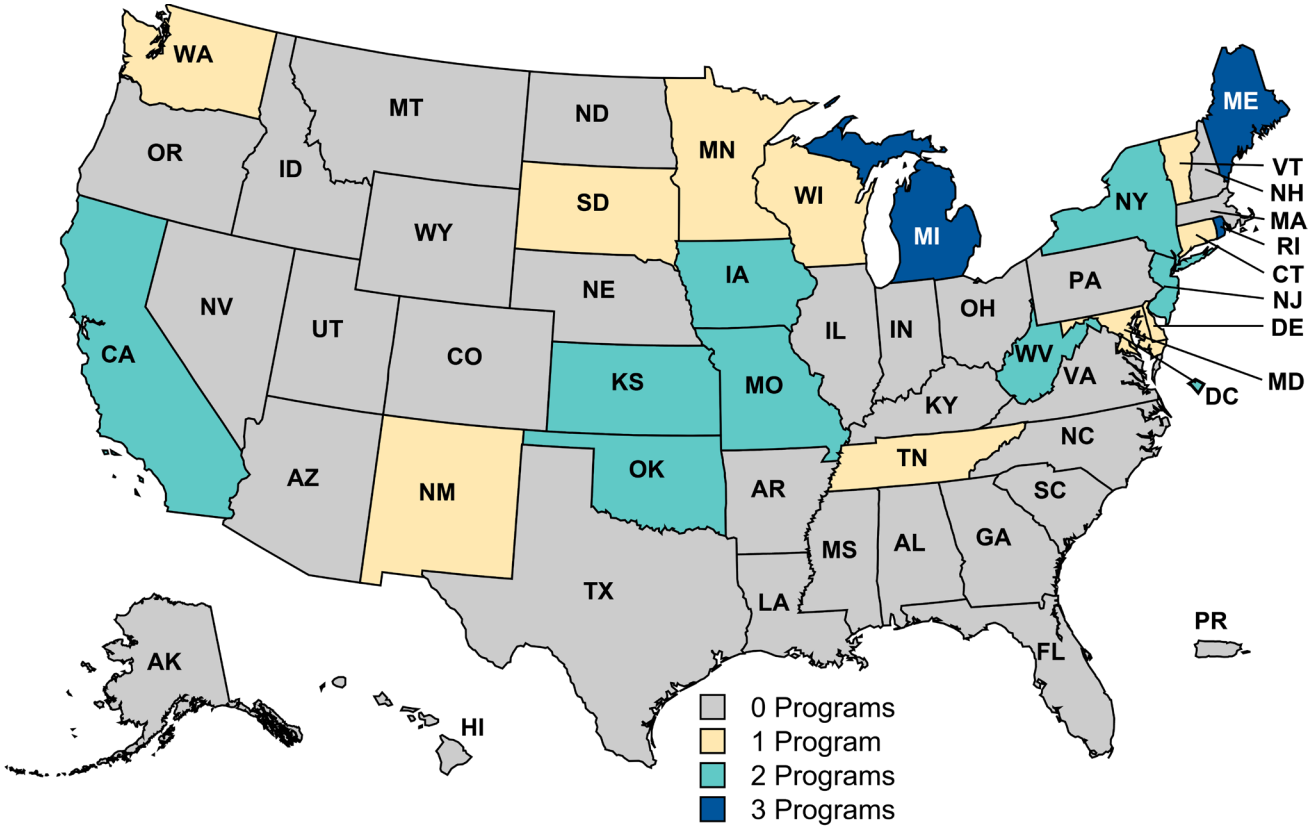
Geographic Variation in Health Home Programs Expected* to Report Health Home Core Set Measures, FFY 2021



*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 2021.

Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, March 2023.

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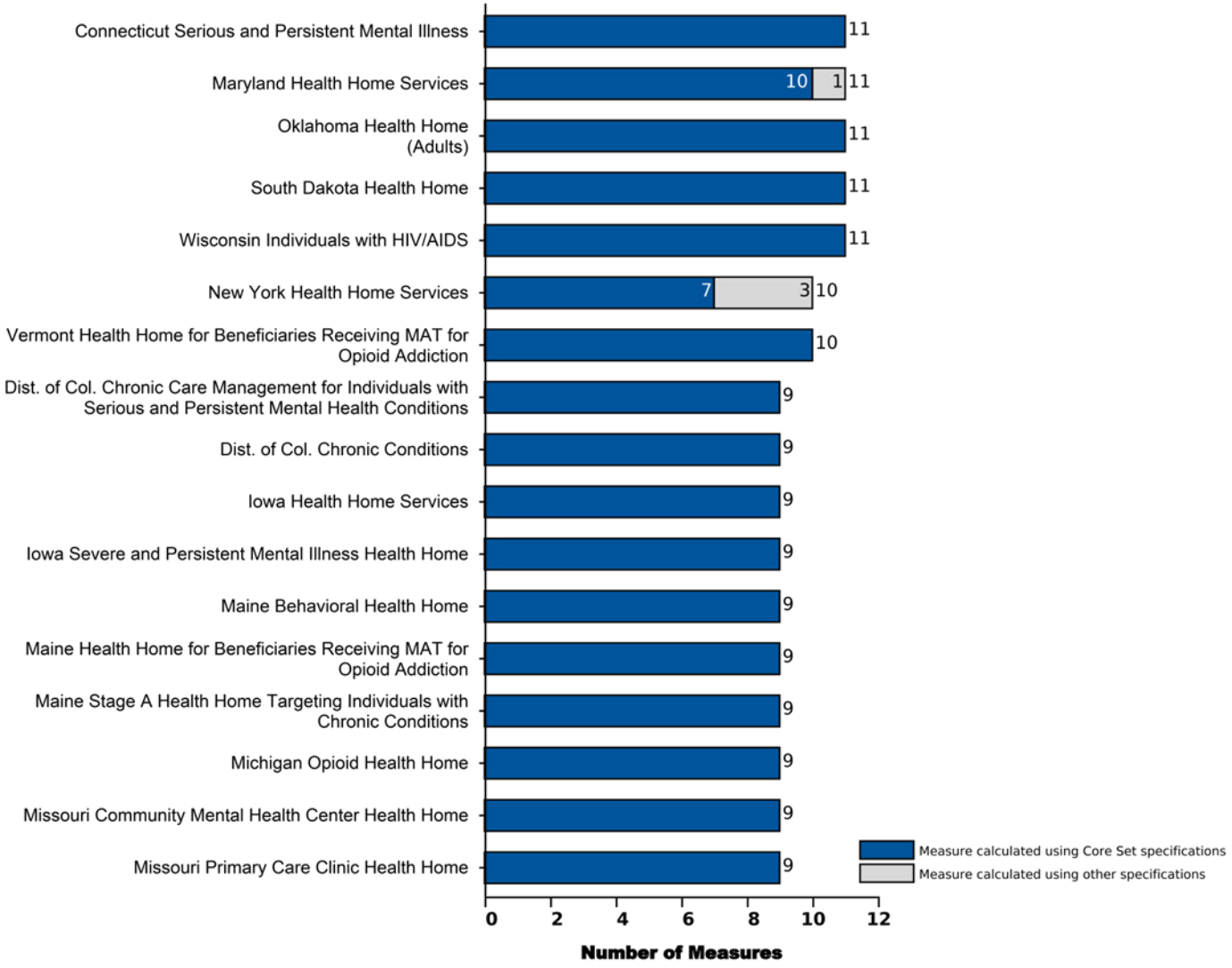
Number of Health Home Core Set Measures Reported for Approved Health Home Programs, FFY 2021



Health Home programs reported a median of

8

Health Home Core Set measures for FFY 2021

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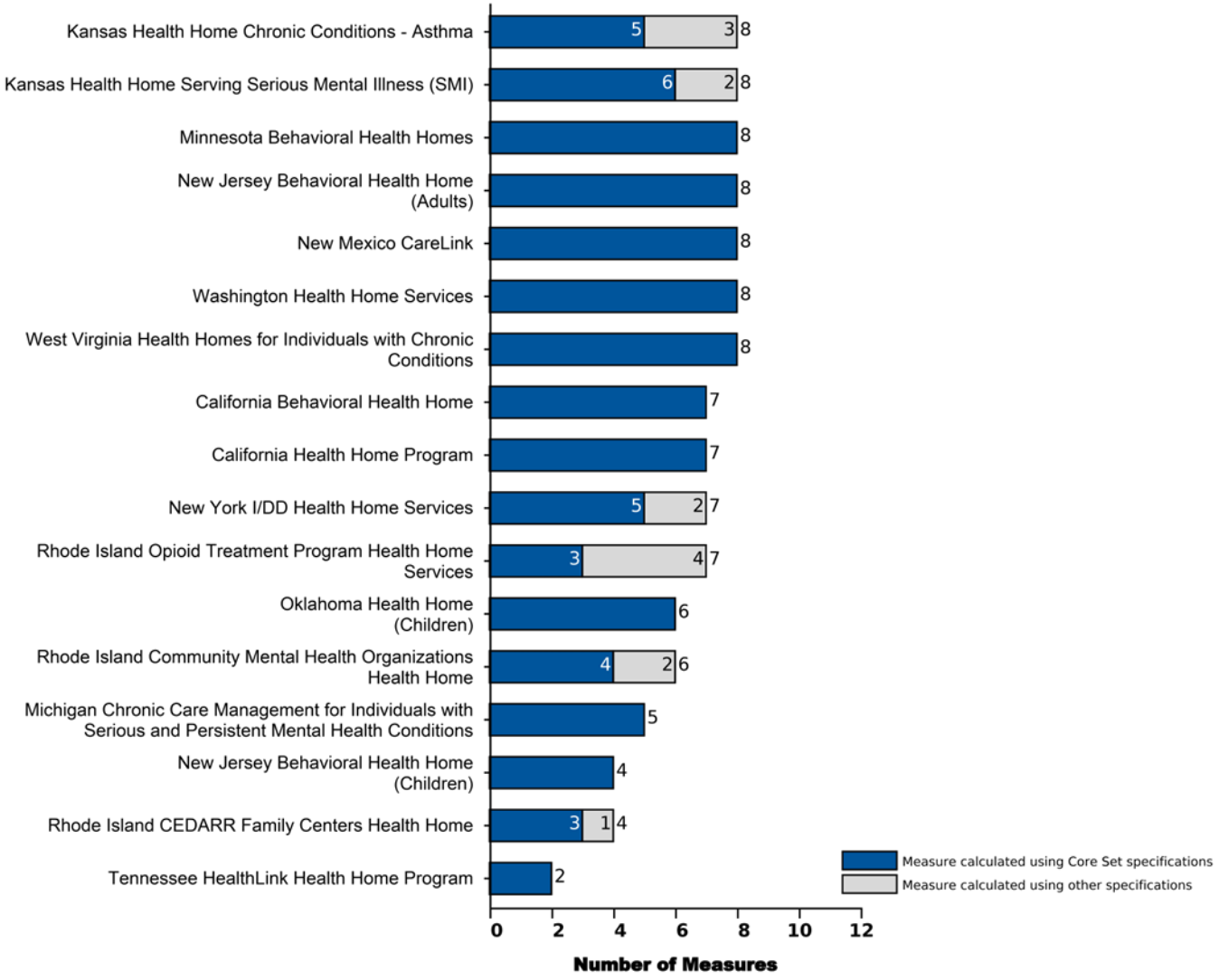
Number of Health Home Core Set Measures Reported for Approved Health Home Programs, FFY 2021

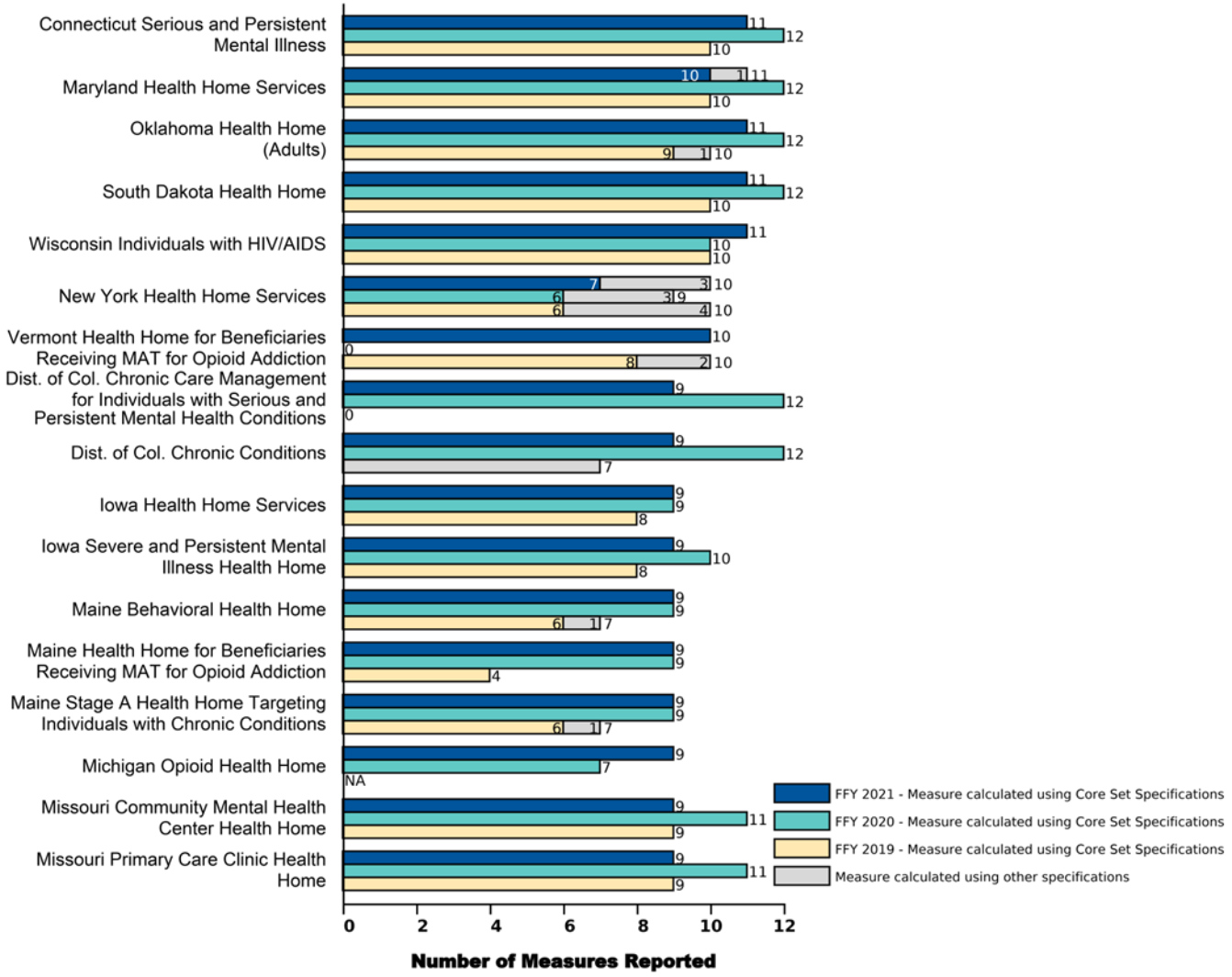


Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: The FFY 2021 Health Home Core Set includes 11 measures, this is a decrease from 12 measures in the 2020 Health Home Core Set. For the purpose of this Chart Pack, "expected" is defined as those Health Home programs meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period). The Delaware Assertive Community Integration Support Team program and Michigan Care Team program are not included, because they did not report data for FFY 2021 by the deadline.
Unless otherwise specified, measures were calculated using Health Home Core Set specifications. Some Health Home Core Set measures were calculated using "other specifications." Measures were denoted as using "other specifications" when the methodology 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; IDD = Intellectual and Developmental Disabilities; MAT = Medication Assisted Treatment

Number of Health Home Core Set Measures Reported for Health Home Programs, FFY 2019–FFY 2021



Reporting remained consistent or increased for

15

of the 26 approved Health Home programs that reported for all three years from FFY 2019 to FFY 2021

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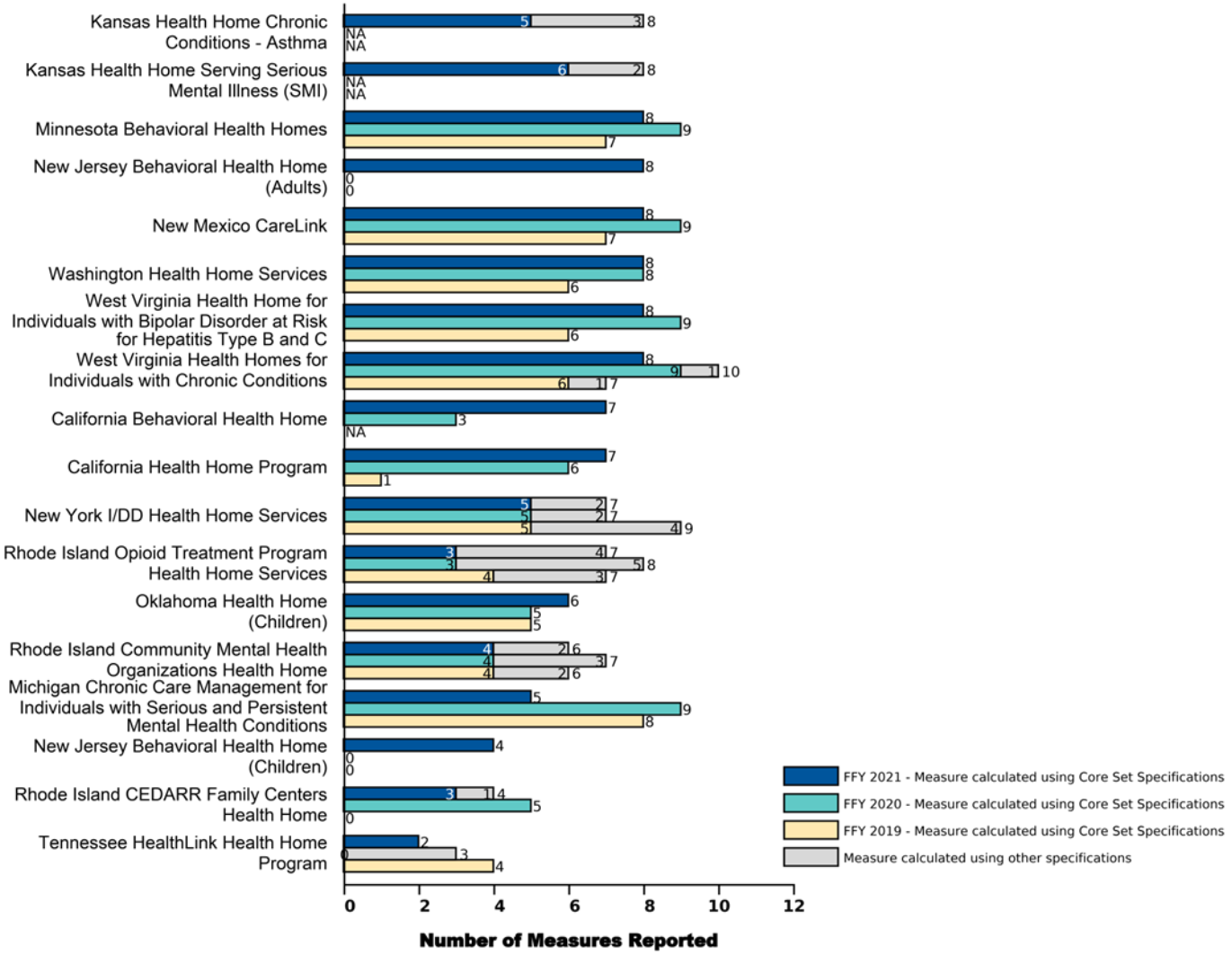
Number of Health Home Core Set Measures Reported for Health Home Programs, FFY 2019–FFY 2021 (continued)



Source: Mathematica analysis of FFY 2019 and 2020 MACPro reports and QMR reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: NA = State was not expected to report for the Health Home for the period. The 2021 Health Home Core Set includes 11 measures. This is a decrease from 12 measures in the 2020 Health Home Core Set. For the purpose of this Chart Pack, "expected" is defined as those Health Home programs meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period).

Unless otherwise specified, measures were calculated using Health Home Core Set specifications. Some Health Home Core Set measures were calculated using "other specifications." Measures were denoted as using "other specifications" when the methodology deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

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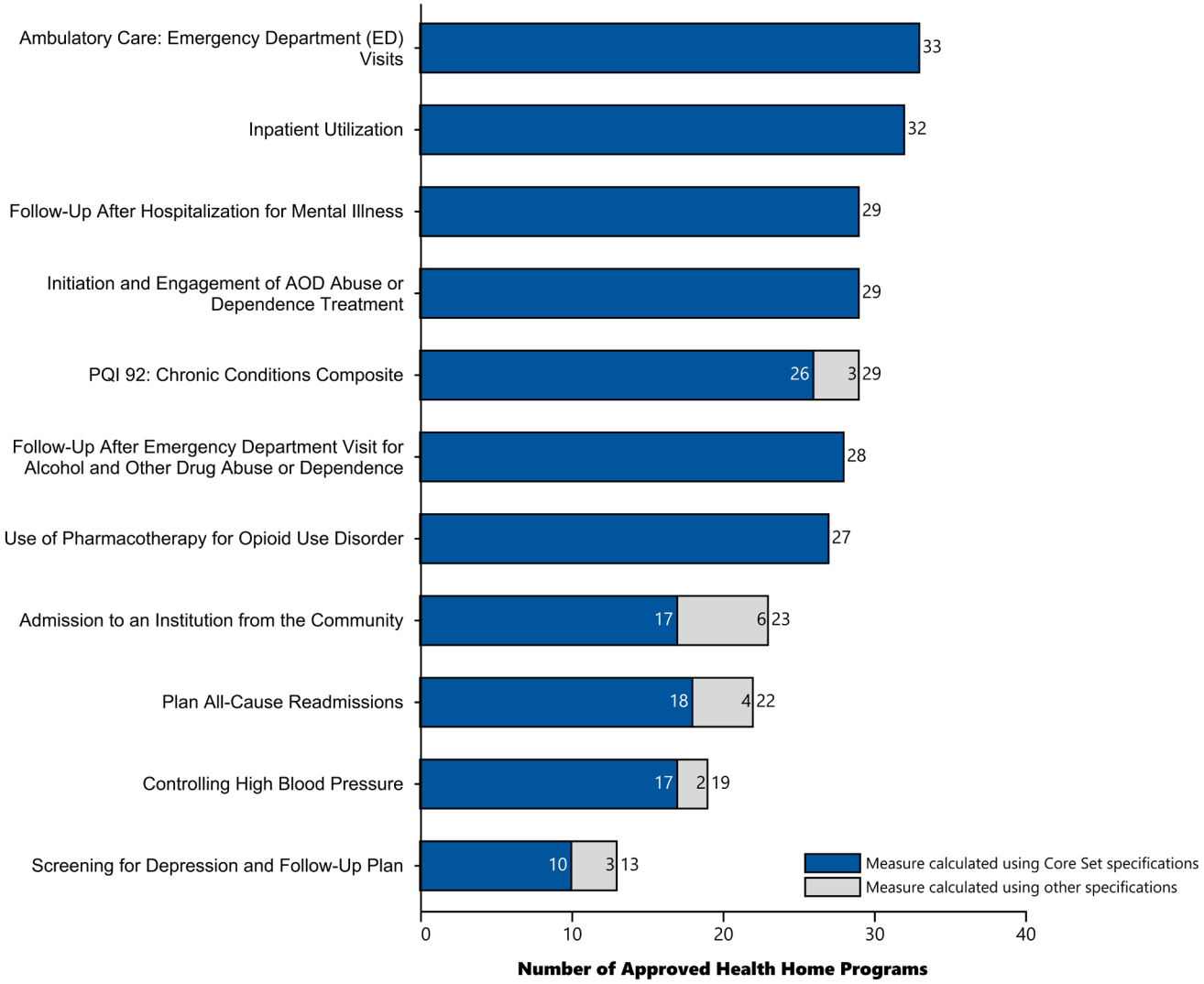
Number of Health Home Programs Reporting the Health Home Core Set Measures, FFY 2021



9 of the 11 Health Home Core Set measures were reported for at least 20 approved Health Home programs for FFY 2021

Source: Mathematica analysis of QMR reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: The 2021 Health Home Core Set includes 8 quality measures and 3 utilization measures. This chart includes all Health Home Core Set measures that States reported for the FFY 2021 reporting cycle.

Unless otherwise specified, measures were calculated using Health Home Core Set specifications. Some Health Home Core Set measures were calculated using "other specifications." Measures were denoted as using "other specifications" when the methodology deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

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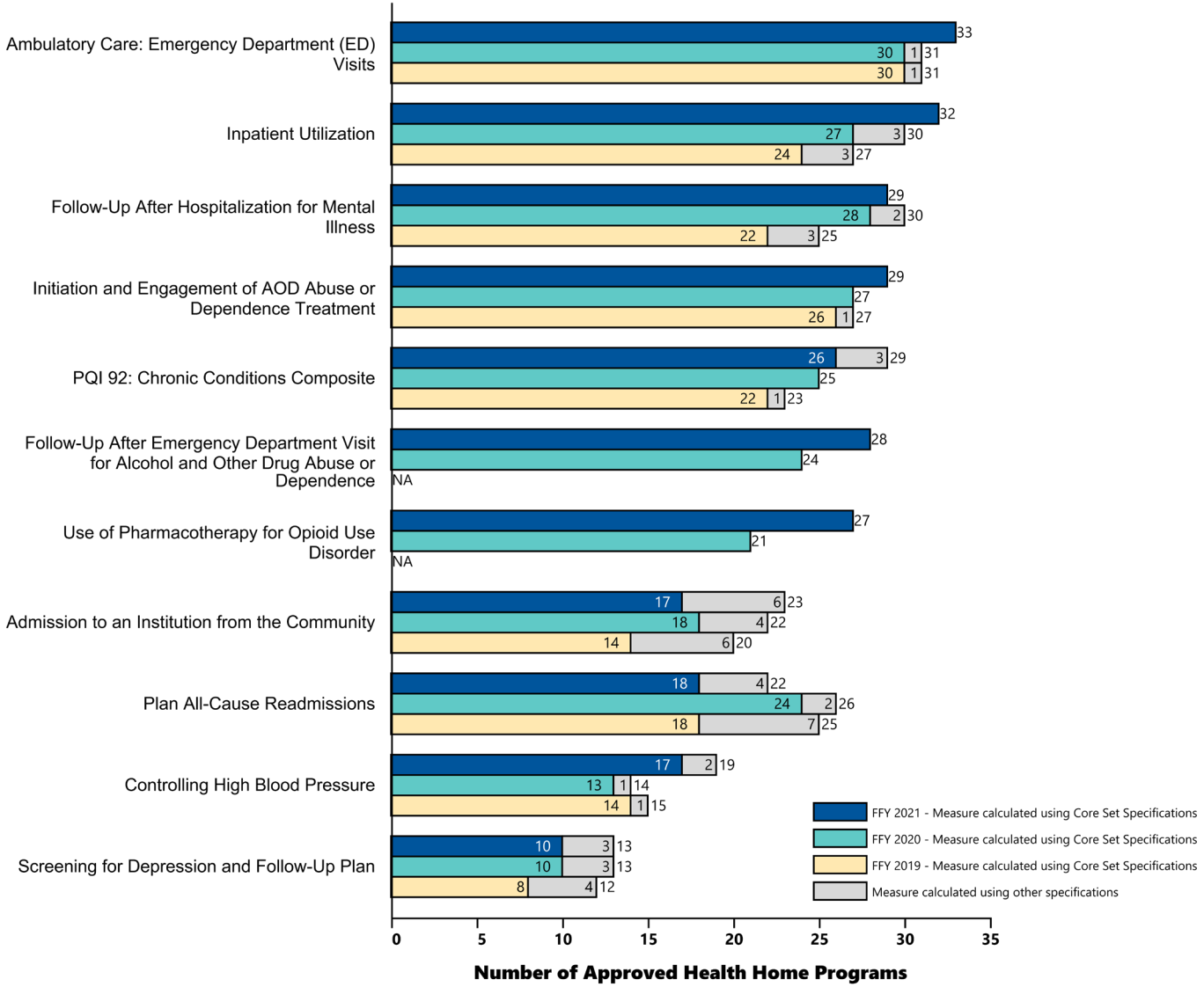
Number of Health Home Programs Reporting the Health Home Core Set Measures, FFY 2019–FFY 2021



Reporting increased or remained the same for

8 of the 9 measures included in both the 2019 and 2021 Health Home Core Sets

Source: Mathematica analysis of FFY 2019 and 2020 MACPro reports and QMR reports for the FFY 2021 reporting cycle as of June 9, 2023.

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: 35 programs for FFY 2019, 37 programs for FFY 2020, and 37 programs for FFY 2021. For the purpose of this Chart Pack, "expected" is defined as those Health Home programs meeting the criteria for voluntarily reporting (i.e., program was in effect for six or more months of the measurement period).

Unless otherwise specified, measures were calculated using Health Home Core Set specifications. Some Health Home Core Set measures were calculated using "other specifications." Measures were denoted as using "other specifications" when the methodology 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.

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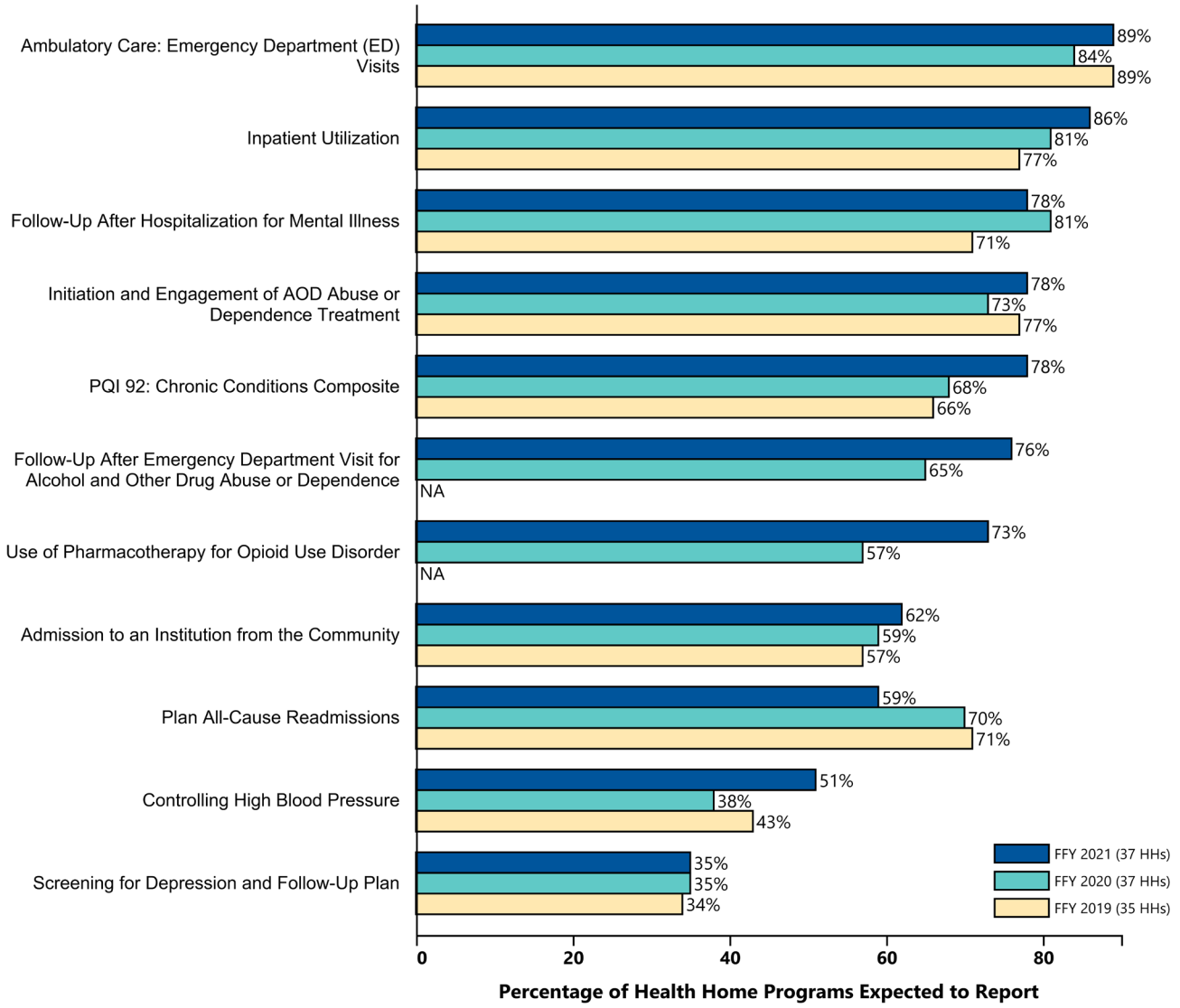
Percentage of Health Home Programs Reporting Health Home Core Set Measures, FFY 2019–FFY 2021



5 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 FFY 2019 and 2020 MACPro reports; Mathematica analysis of QMR reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: NA= not applicable; measure not included in the Health Home Core Set for the reporting period.

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

HH = approved Health Home program.

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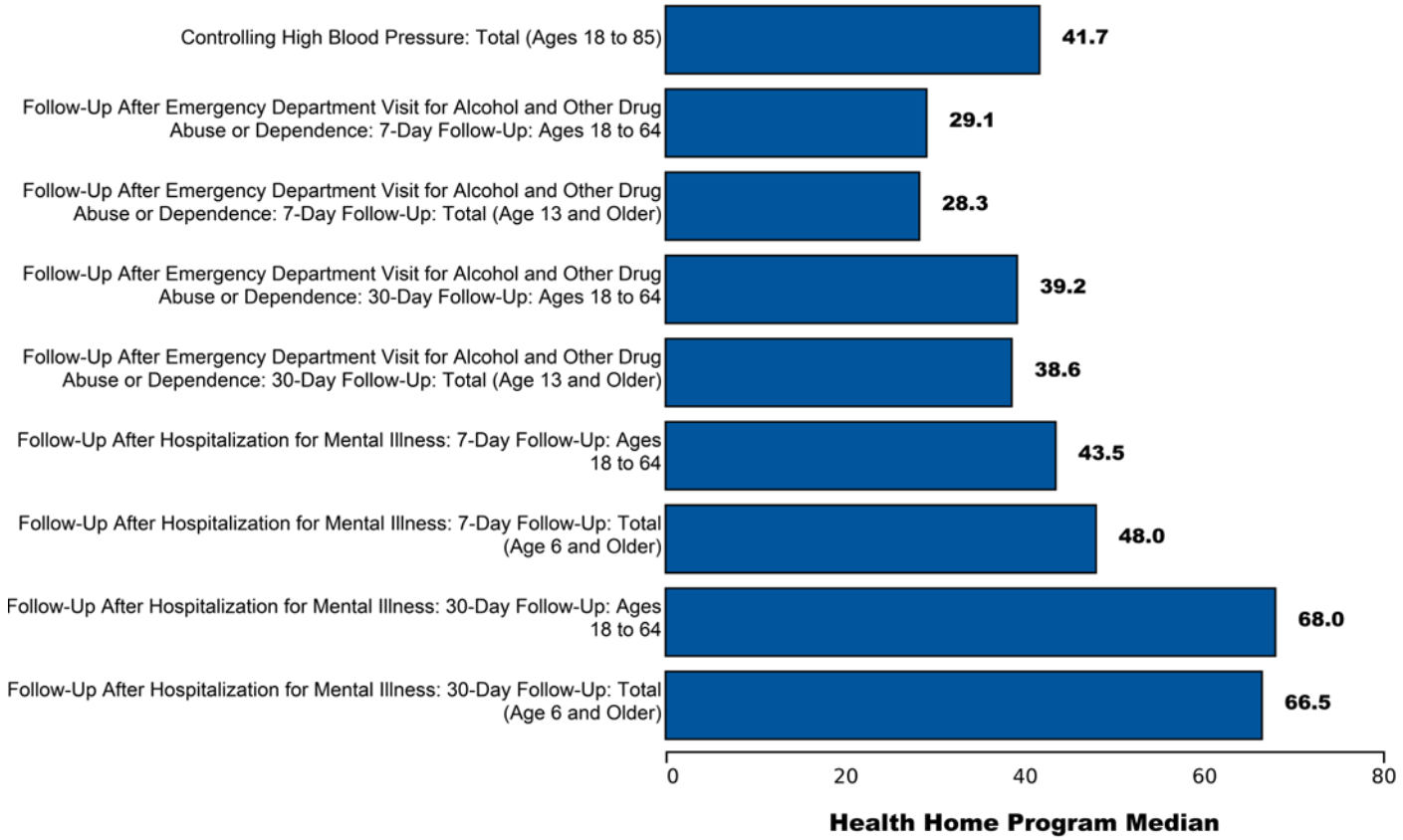
Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021



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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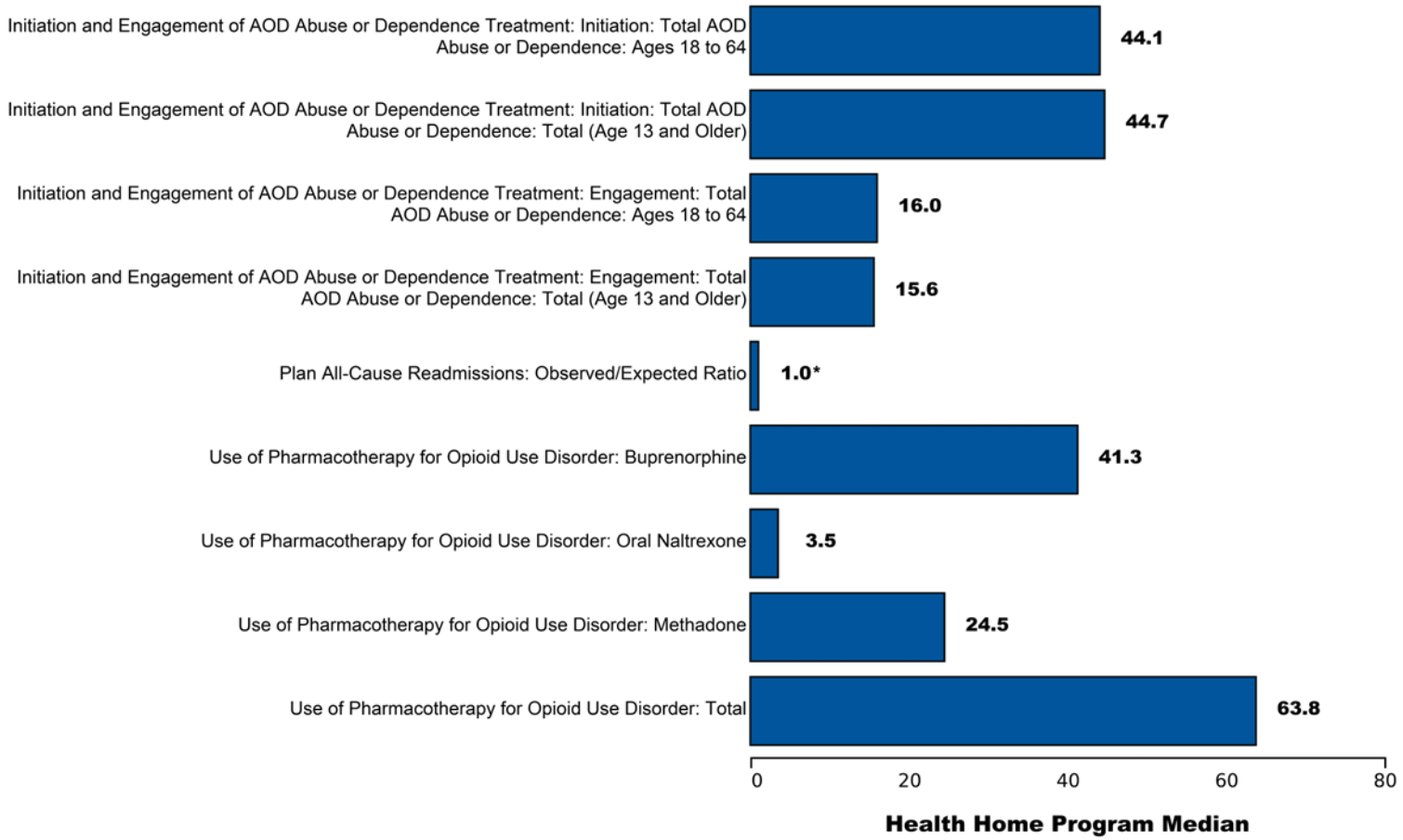
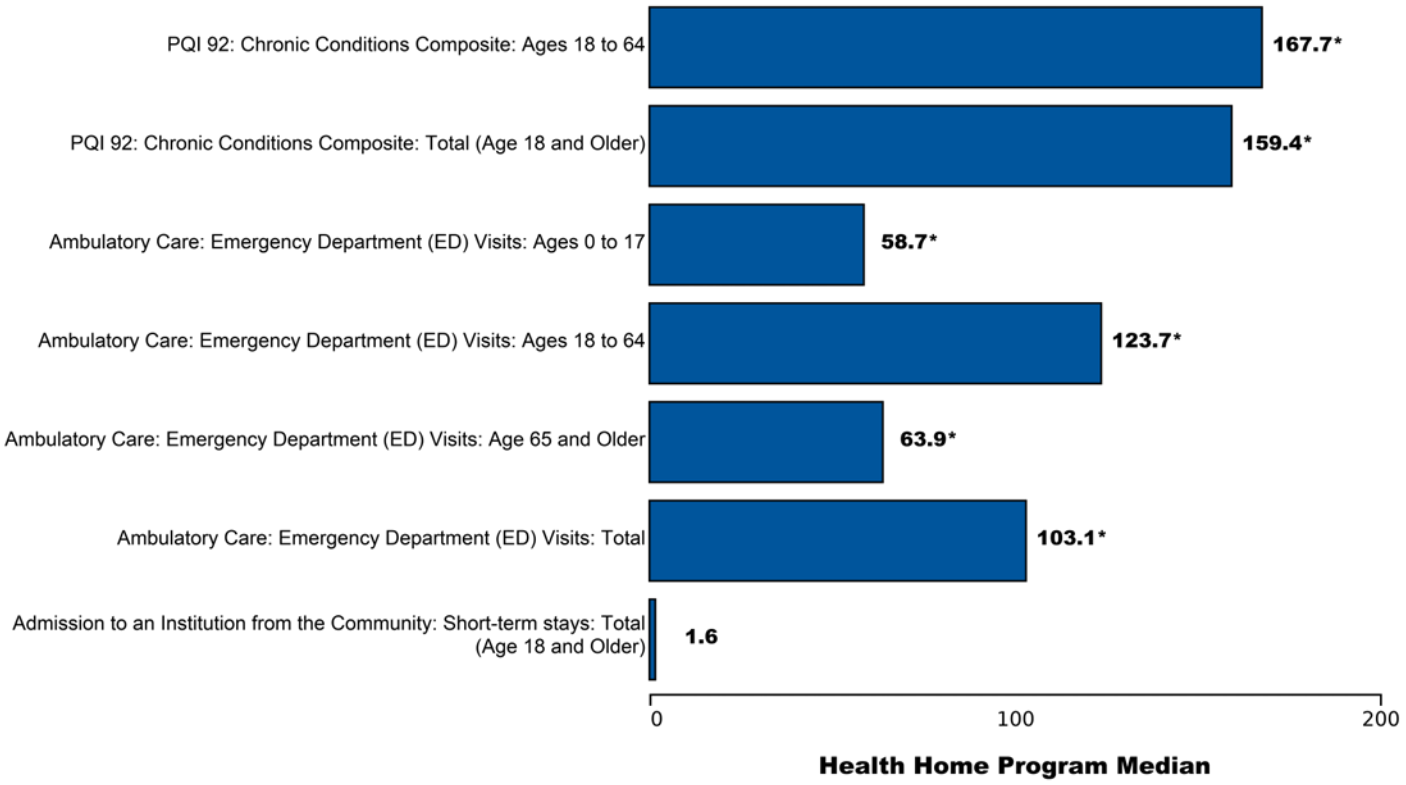
Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021 (continued)



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.

Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021 (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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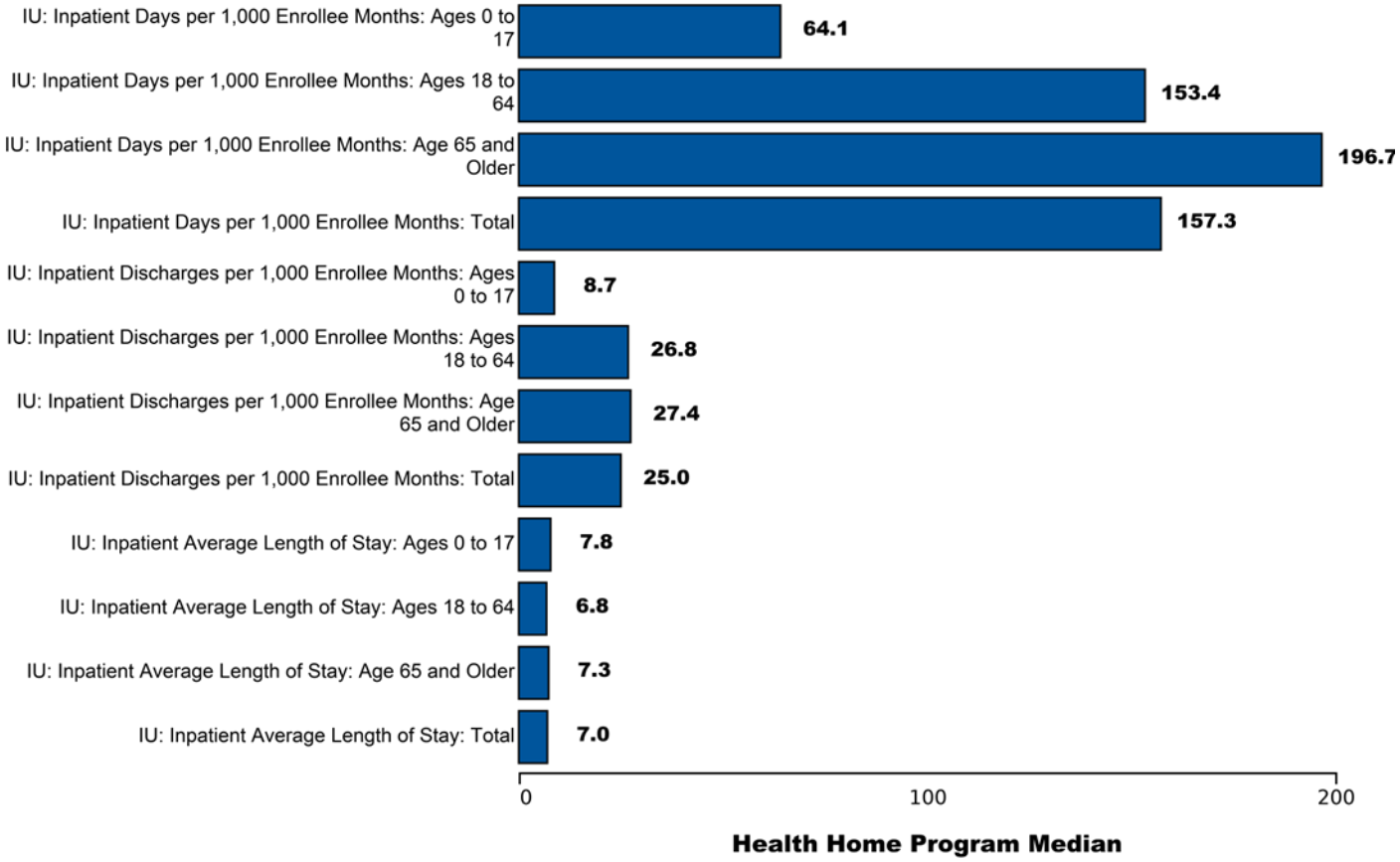
Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021 (continued)



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: This chart includes measures that were reported by at least 15 approved Health Home programs for FFY 2021 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.

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Performance on the Health Home Core Set Measures, FFY 2021

Performance Data for Selected FFY 2021 Health Home Core Set Measures

Of the 11 Health Home Core Set measures, 10 were available for performance analysis for FFY 2021. 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

- 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 Dependence Treatment
- Use of Pharmacotherapy for Opioid Use Disorder
- Plan All-Cause Readmissions
- PQI 92: Chronic Conditions Composite

Utilization Measures

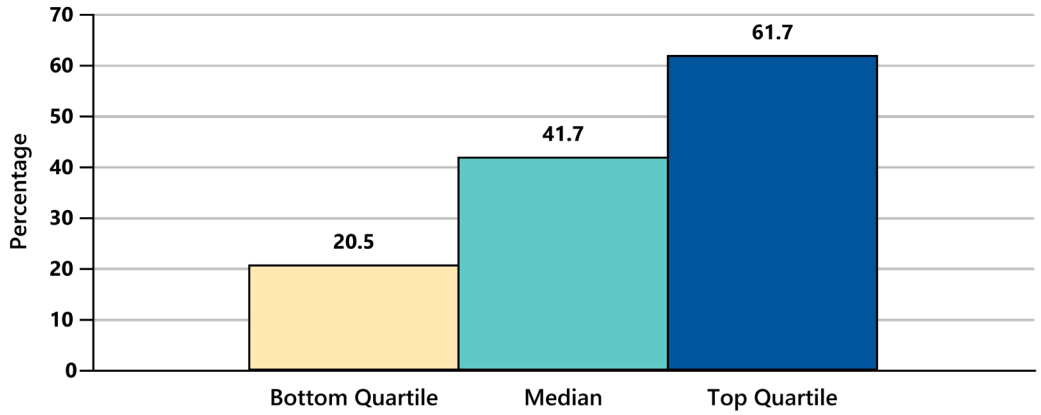
- Admission to an Institution from the Community
- Ambulatory Care: Emergency Department Visits
- Inpatient Utilization

[1] A methods brief describing the criteria for assessing performance on the Health Home Core Set measures is available at https://www.medicaid.gov/media/131916

Controlling High Blood Pressure

High blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States. Controlling high blood pressure is an important step in preventing heart attacks, strokes, and kidney disease, and in reducing the risk of developing other serious conditions. This measure assesses the percentage of Health Home enrollees who had a diagnosis of hypertension and whose blood pressure was adequately controlled. Performance on this measure is being publicly reported for the first time in FFY 2021.

Percentage of Health Home Enrollees Ages 18 to 85 who had a Diagnosis of Hypertension and whose Blood Pressure was Adequately Controlled (CBP-HH), FFY 2021 (n = 15 HHs)



Source: Mathematica analysis of the QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

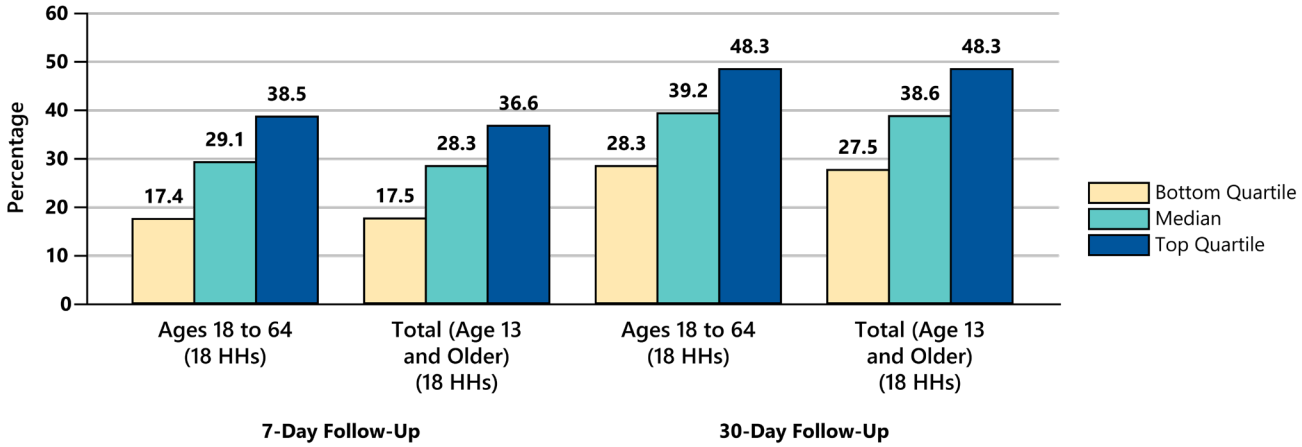
Notes: This measure shows the percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. Rates for Ages 18 to 64 and Age 65 to 85 are not shown because fewer than 15 Health Home programs reported these rates for FFY 2021. This chart excludes NY Health Home Services and RI Opioid Treatment Program Health Home Services, which calculated 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: KS Health Home Chronic Conditions – Asthma, KS Health Home Serving Serious Mental Illness (SMI), MI Chronic Care Model, MI Opioid Health Home, NJ Behavioral Health Home (Adults), OK Health Home (Adults), and WV Health Home for Individuals with Chronic Conditions.

A median of **42** percent of Health Home enrollees with hypertension had their blood pressure adequately controlled (15 HHs)

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.

Percentage of Emergency Department (ED) Visits for Health Home Enrollees Age 13 and Older who had 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 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9,2023.

Notes: 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 who 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 2021. 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, DC Chronic Conditions, IA Health Home Services, KS Health Home Chronic Conditions – Asthma, KS Health Home Serving Serious Mental Illness (SMI), MI Opioid Health Home, NJ Behavioral Health Home (Adults), OK Health Home (Children) for Total (Ages 13 and Older) for 7-Day and 30-Day Follow-Up rates, SD Health Home, and WI Individuals with HIV/AIDS.

A median of

28 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 and

39 percent had a follow-up visit within 30 days (18 HHs)

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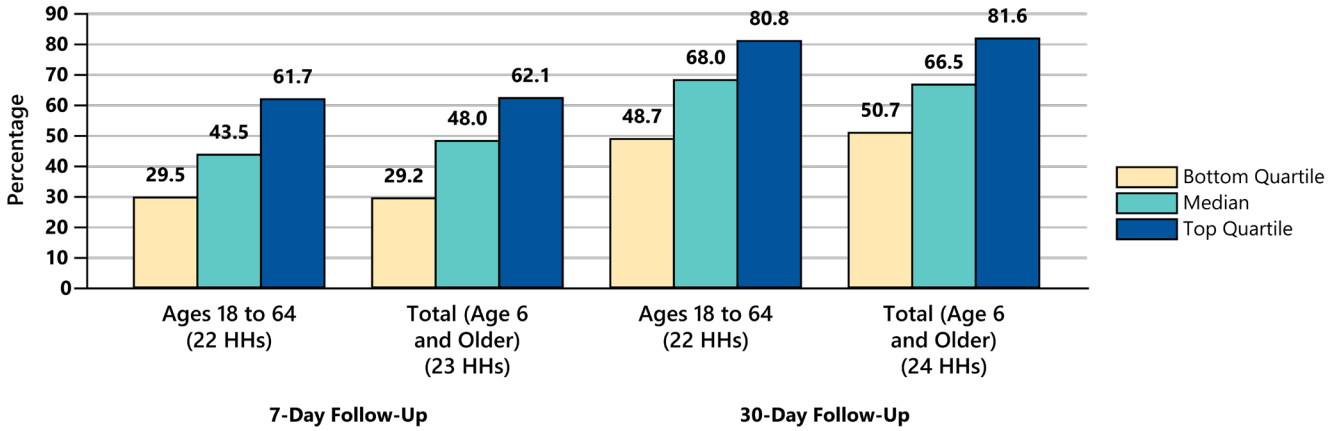
Follow-Up After Hospitalization for Mental Illness

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 provider within 30 days after discharge and ideally, within 7 days after 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 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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 and who had a follow-up visit with a mental health provider. Two rates are reported: (1) the percentage of discharges for which the enrollee received follow-up within 7 days after discharge; and (2) the percentage of discharges for which the enrollee 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 2021. Data were suppressed for the following Health Home programs due to small cell sizes: IA Health Home Services for Ages 18 to 64 and Total for both rates, KS Health Home Chronic Conditions – Asthma for Ages 18 to 64 and Total for 7-day rate and for Ages 18 to 64 for 30-day rate, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Ages 18 to 64 and Total for both rates, Michigan Opioid Health Home for Ages 18 to 64 and Total for both rates, OK Health Home (Adults) for Ages 18 to 64 and Total for both rates, OK Health Home (Children) for Total for both rates, and WI Individuals with HIV/AIDS for Ages 18 to 64 for both rates.

A median of

48 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 (23 HHs) and

67 percent

had a follow-up visit within 30 days after discharge (24 HHs)

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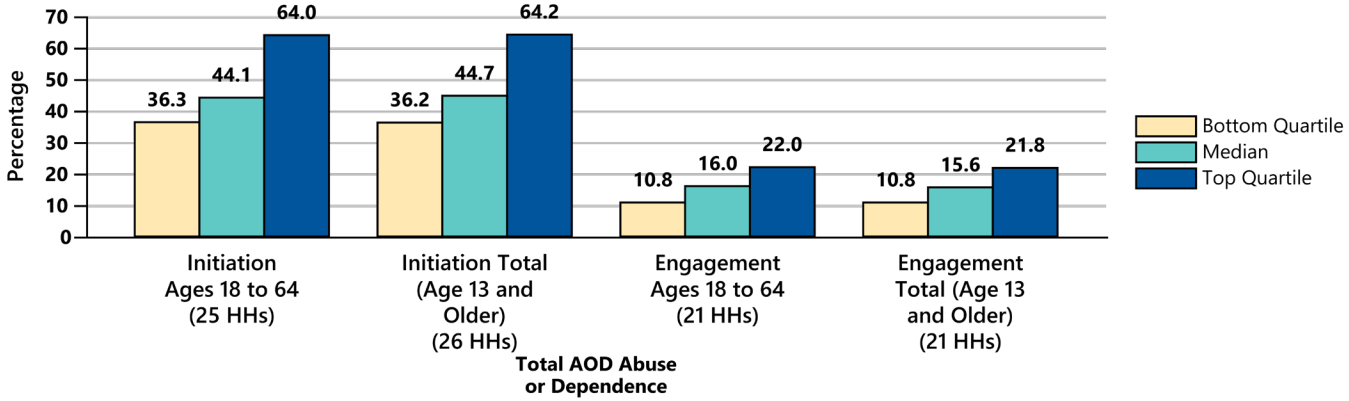
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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).

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 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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 2021. Data were suppressed for the following Health Home programs due to small cell sizes: IA Severe and Persistent Mental Illness for the Total (Age 13 and Older) Engagement rate, KS Health Home Chronic Conditions – Asthma for the Total (Age 13 and Older) Engagement rate, KS Health Home Serving Serious Mental Illness (SMI) for the Total (Age 13 and Older) Engagement rate, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for the Total (Age 13 and Older) both rates, NJ Behavioral Health Home (Adults) for the Total (Age 13 and Older) Engagement rate, OK Health Home (Adults) for the Total (Age 13 and Older) Engagement rate, OK Health Home (Children) for the Total (Age 13 and Older) both rates, and SD Health Home for the Total (Age 13 and Older) both rates.

A median of

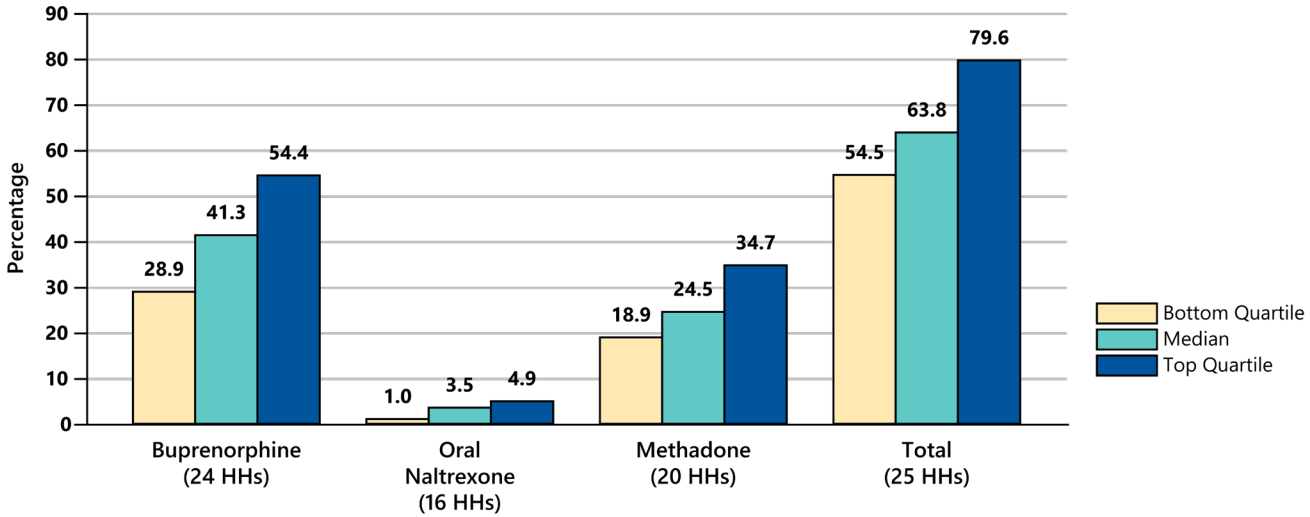
45 percent of Health Home enrollees age 13 and older with alcohol or other drug abuse or dependence initiated treatment within 14 days of diagnosis (26 HHs)

16 percent of Health Home enrollees age 13 and older with alcohol or other drug abuse or dependence engaged in treatment within 34 days of the initiation visit.

Use of Pharmacotherapy for Opioid Use Disorder

Pharmacotherapy, or use of medications to treat opioid use disorder (OUD), decreases opioid use and opioid-related overdose deaths among adults. It also increases retention in treatment. This measure shows the percentage of Health Home enrollees ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed a U.S. Food and Drug Administration (FDA)-approved medication for the disorder during the measurement year.

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 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: This measure shows the percentage of Health Home enrollees ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for 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). The rate for Long-acting Injectable Naltrexone is not shown because fewer than 15 Health Home programs reported this rate for FFY 2021. Data were suppressed for the following Health Home programs due to small cell sizes: IA Health Home Services for Methadone, MI Opioid Health Home for Methadone, MO Community Mental Health Center Health Home for Methadone, MO Primary Care Clinic for Methadone, OK Health Home (Adults) for Buprenorphine, Methadone, and Total, SD Health Home for Methadone, and WI Individuals with HIV/AIDS for Buprenorphine and Methadone.

A median of

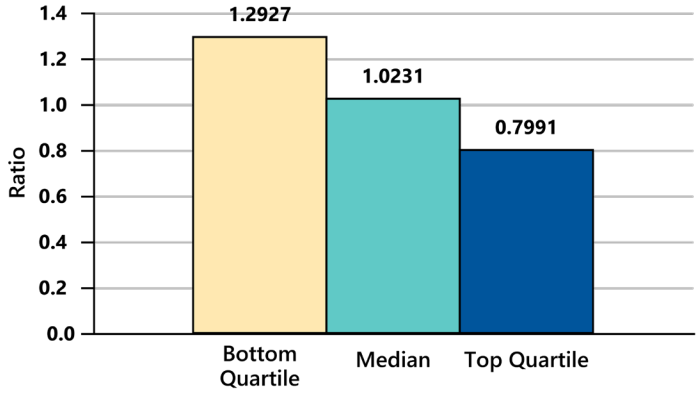
64

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 (25 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 2021 (n = 18 HHs) [Lower rates are better for this measure]



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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. This chart excludes KS Health Home Chronic Conditions - Asthma, KS Health Home Serving Serious Mental Illness (SMI), RI Community Mental Health Organizations Health Home, and RI 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: DC Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction, and WI Individuals with HIV/AIDS.

Of the 18 approved Health Home programs reporting the measure,

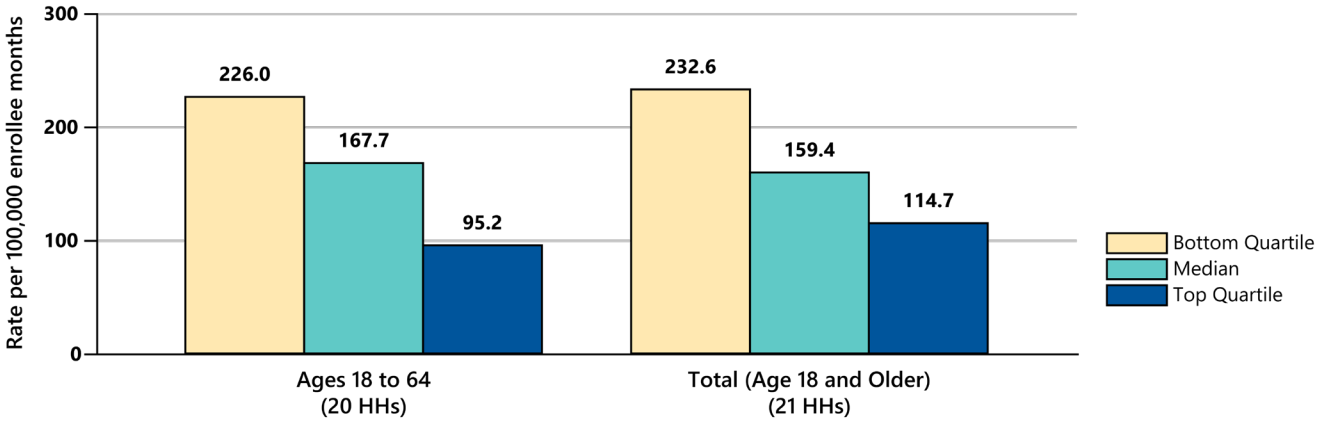
7

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 2021 [Lower rates are better for this measure]



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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. Rates for Age 65 and older are not shown because fewer than 15 Health Home programs reported these rates for FFY 2021. This chart excludes KS Health Home Chronic Conditions - Asthma, 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: KS Health Home Serving Serious Mental Illness (SMI) for Ages 18 to 64 and Total, MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions for Ages 18 to 64 and Total, MI Opioid Health Home for Ages 18 to 64 and Total, OK Health Home (Adults) for Ages 18 to 64 and Total, RI CEDARR Family Centers Health Home for Ages 18 to 64 and Total, and WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Ages 18 to 64.

Health Home enrollees age 18 and older had a median of

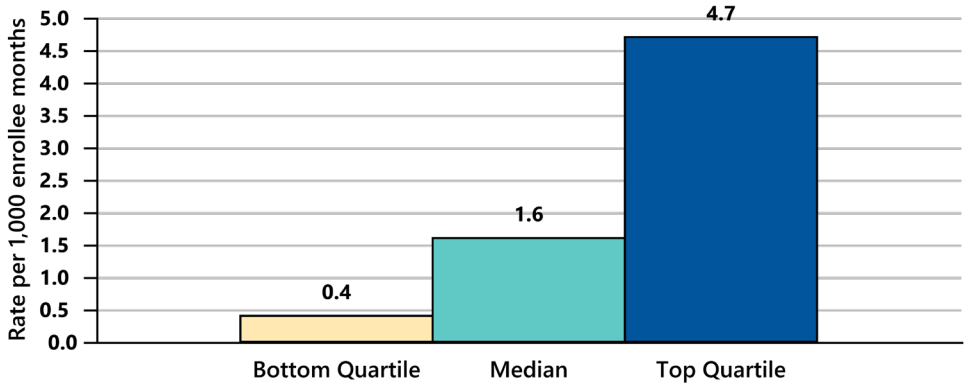
159

inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months (21 HHs)

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.

Number of Admissions to an Institution from the Community that Result in a Short-Term Stay per 1,000 Enrollee Months for Health Home Enrollees Age 18 and Older (AIF-HH), FFY 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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. Long-term and medium-term stay rates are not shown because fewer than 15 Health Home programs reported these rates for FFY 2021. This chart excludes the KS Health Home Chronic Conditions - Asthma, KS Health Home Serving Serious Mental Illness (SMI), NY Health Home Services, NY I/DD Health Home Services, RI Community Mental Health Organizations Health Home, and RI 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: RI CEDARR Family Centers Health Home for short-term stays and WI Individuals with HIV/AIDS for short-term stays.

Health Home enrollees age 18 and older had a median of

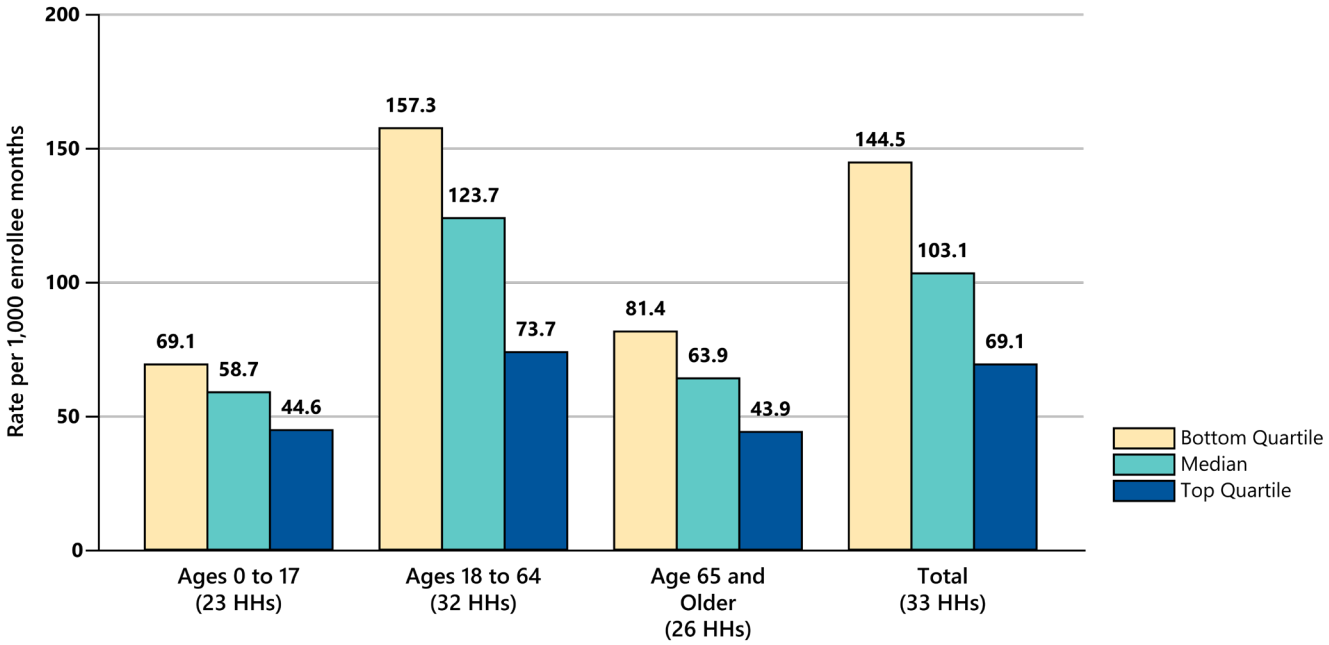
1.6

short-term stays in an institutional facility per 1,000 enrollee months (15 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.

Rate of Emergency Department Visits per 1,000 Enrollee Months for Health Home Enrollees (AMB-HH), FFY 2021 [Lower rates are better for this measure]



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: This measure shows the rate of emergency department visits per 1,000 enrollee months among Health Home enrollees. Data were suppressed for the following Health Home programs due to small cell sizes: KS Health Home Serving Serious Mental Illness (SMI) for Age 65 and Older, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, NM CareLink for Age 65 and Older, and WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Ages 0 to 17.

Health Home enrollees had a median of

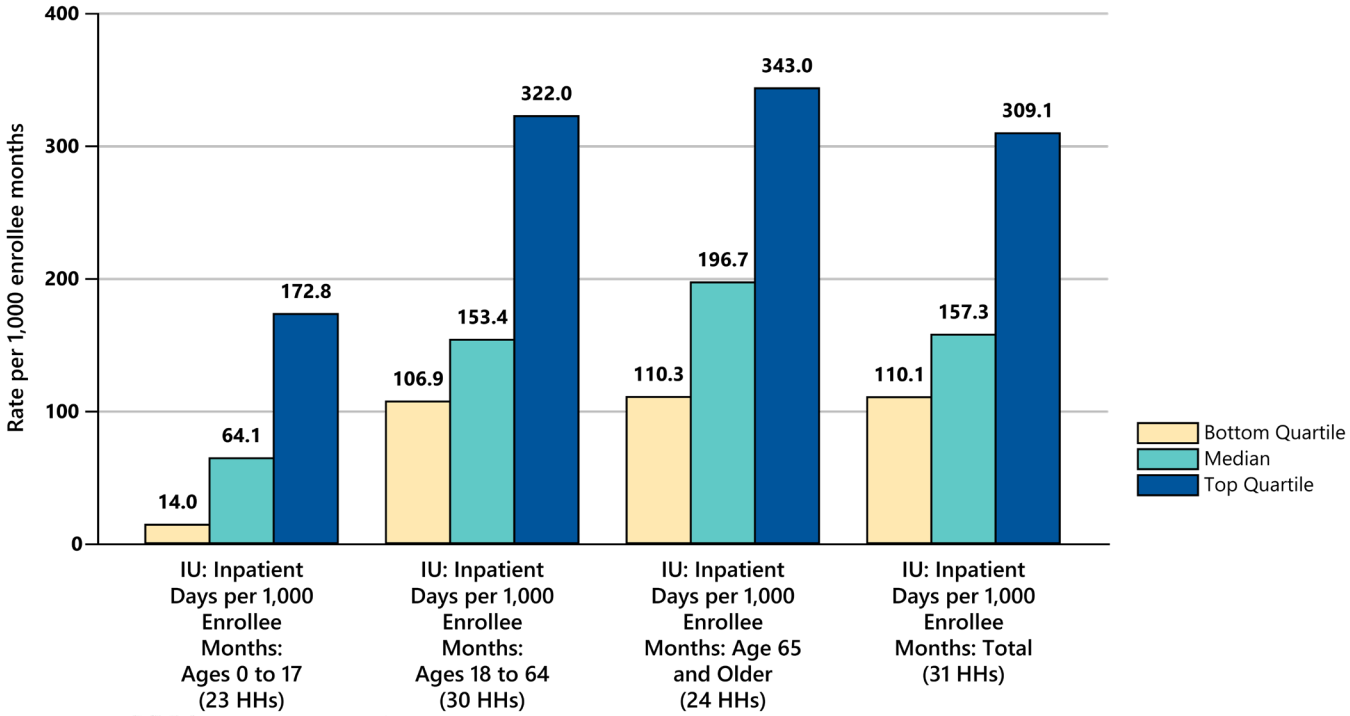
103

emergency department visits per 1,000 enrollee months (33 HHs)

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 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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 MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, 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: CT Serious and Persistent Mental Illness for Ages 0 to 17, IA Health Home Services for Ages 0 to 17, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, and NM CareLink for Age 65 and Older.

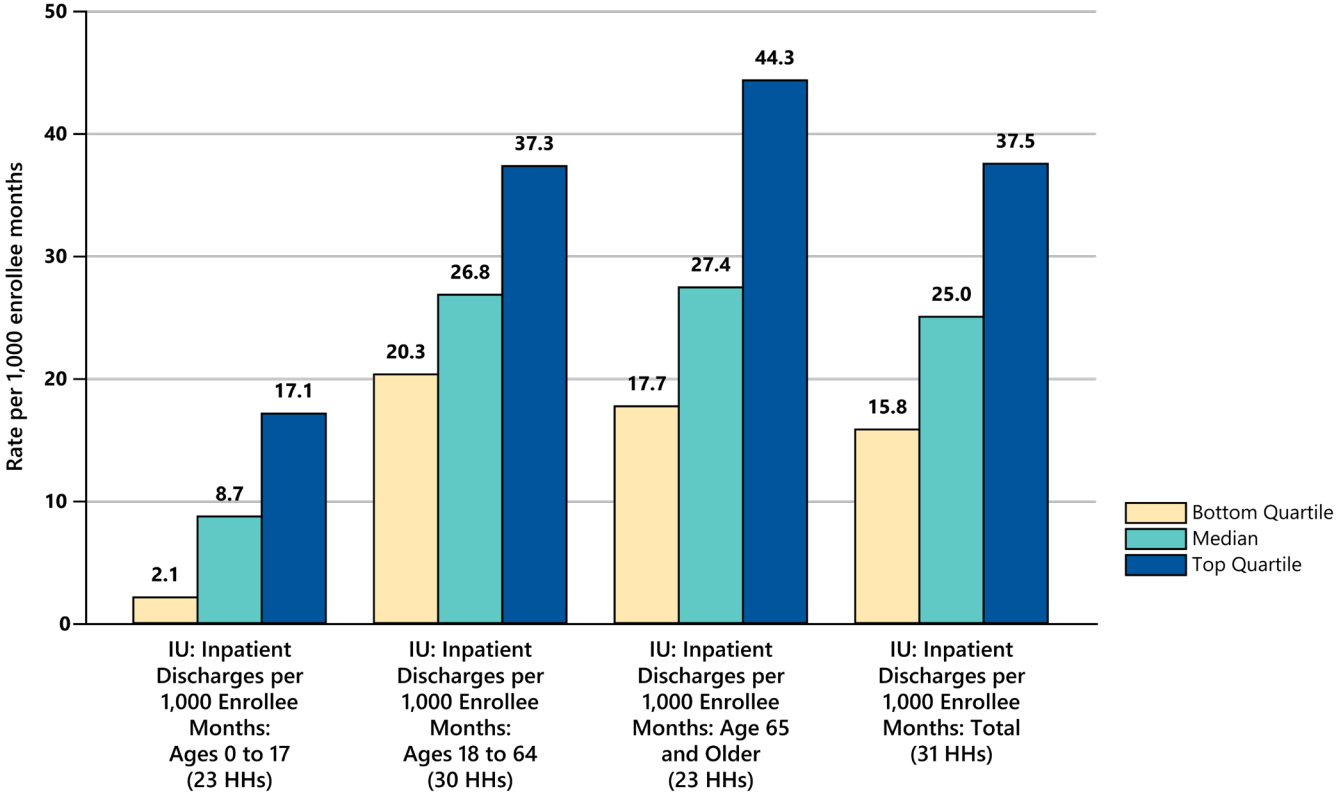
Health Home enrollees spent a median of

157

days in the hospital per 1,000 enrollee months (31 HHs)

Inpatient Utilization: Inpatient Discharges (continued)

Discharges from Acute Inpatient Care and Services per 1,000 Enrollee Months for Health Home Enrollees (IU-HH), FFY 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: 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 MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, 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: CT Serious and Persistent Mental Illness for Ages 0 to 17, IA Health Home Services for Ages 0 to 17, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, NM CareLink for Age 65 and Older, and WI Individuals with HIV/AIDS for Age 65 and Older.

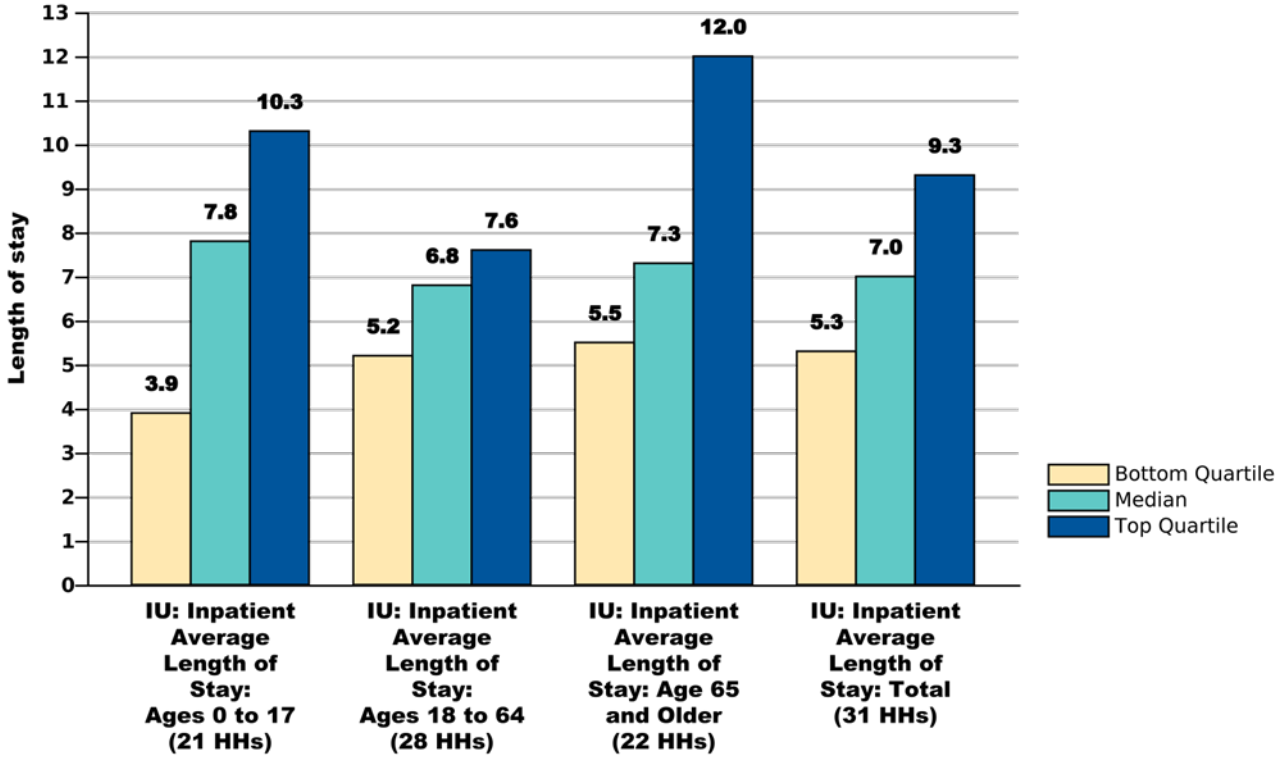
Health Home enrollees had a median of

25

inpatient hospital discharges per 1,000 enrollee months (31 HHs)

Inpatient Utilization: Inpatient Length of Stay (continued)

Average Length of Stay of Acute Inpatient Care and Services for Health Home Enrollees (IU-HH), FFY 2021



Source: Mathematica analysis of QMR system reports for the FFY 2021 reporting cycle as of June 9, 2023.

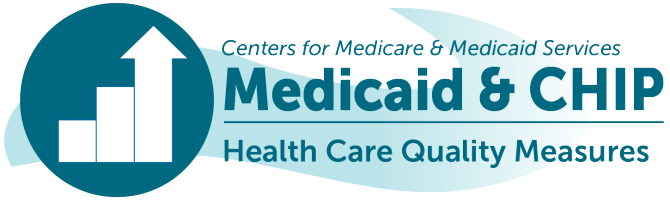
Notes: This measure shows the rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months among Health Home enrollees. This chart excludes the MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, 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: CT Serious and Persistent Mental Illness for Ages 0 to 17, IA Health Home Services for Ages 0 to 17, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MN Behavioral Health Homes for Ages 0 to 17, NJ Behavioral Health Home (Children) for Ages 18 to 64, RI CEDARR Family Centers Health Home for Ages 18 to 64, RI Opioid Treatment Program Health Home Services 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 for Ages 0 to 17, and WI Individuals with HIV/AIDS for Age 65 and Older.

The median length of hospital stays for Health Home enrollees was

7

days per discharge (31 HHs)

REFERENCE TABLES AND ADDITIONAL RESOURCES



Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2021

	Number of Measures Reported	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 Depression and Follow-Up Plan	Admission to an Institution from the Community	Ambulatory Care: Emergency Department Visits	Inpatient Utilization
Total	8 (Median)	19	28	29	29	27	22	29	13	23	33	32
California Health Home Program	7	--	X	X	X	X	--	--	--	X	X	X
California Behavioral Health Home	7	--	X	X	X	X	--	--	--	X	X	X
Connecticut Serious and Persistent Mental Illness	11	X	X	X	X	X	X	X	X	X	X	X
Dist. of Col. Chronic Conditions	9	--	X	X	X	X	X	X	--	X	X	X
Dist. of Col. Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	9	--	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	9	--	X	X	X	X	X	X	--	X	X	X
Kansas Health Home Serving Serious Mental Illness (SMI)	8	X	X	X	X	--	X	X	--	X	X	--
Kansas Health Home Chronic Conditions - Asthma	8	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	11	X	X	X	X	X	X	X	X	X	X	X

Table is continued on the next slide.

Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2021 (continued)

	Number of Measures Reported	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 Depression and Follow-Up Plan	Admission to an Institution from the Community	Ambulatory Care: Emergency Department Visits	Inpatient Utilization
Michigan Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	5	X	--	--	--	--	--	X	--	X	X	X
Michigan Opioid Health Home	9	X	X	X	X	X	--	X	X	--	X	X
Minnesota Behavioral Health Homes	8	--	X	X	X	X	X	X	--	--	X	X
Missouri Community Mental Health Center Health Home	9	X	X	X	X	X	X	X	--	--	X	X
Missouri Primary Care Clinic Health Home	9	X	X	X	X	X	X	X	--	--	X	X
New Jersey Behavioral Health Home (Adults)	8	X	X	--	X	X	--	X	X	--	X	X
New Jersey Behavioral Health Home (Children)	4	--	--	--	--	--	--	X	X	--	X	X
New Mexico CareLink	8	--	X	X	X	X	X	X	--	--	X	X
New York Health Home Services	10	X	X	X	X	X	--	X	X	X	X	X
New York I/DD Health Home Services	7	--	--	X	X	--	--	X	X	X	X	X
Oklahoma Health Home (Adults)	11	X	X	X	X	X	X	X	X	X	X	X
Oklahoma Health Home (Children)	6	--	X	X	X	--	--	--	X	--	X	X
Rhode Island CEDARR Family Centers Health Home	4	--	--	--	--	--	--	X	X	X	--	X
Rhode Island Community Mental Health Organizations Health Home	6	X	--	--	--	X	X	--	--	X	X	X
Rhode Island Opioid Treatment Program Health Home Services	7	X	--	--	--	X	X	--	X	X	X	X

Table is continued on the next slide.

Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2021 (continued)

	Number of Measures Reported	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 Depression and Follow-Up Plan	Admission to an Institution from the Community	Ambulatory Care: Emergency Department Visits	Inpatient Utilization
South Dakota Health Home	11	X	X	X	X	X	X	X	X	X	X	X
Tennessee HealthLink Health Home Program	2	X	--	X	--	--	--	--	--	--	--	--
Vermont Health Home for Beneficiaries Receiving MAT for Opioid Addiction	10	X	X	X	X	X	X	X	--	X	X	X
Washington Health Home Services	8	--	X	X	X	X	X	X	--	--	X	X
West Virginia Health Homes for Individuals with Chronic Conditions	8	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	8	X	X	X	X	X	--	X	--	--	X	X
Wisconsin Individuals with HIV/AIDS	11	X	X	X	X	X	X	X	X	X	X	X

Source: Mathematica analysis of QMR reports for the FFY 2021 reporting cycle as of June 9, 2023.

Notes: The 2021 Health Home Core Set includes 11 measures. The following approved Health Home programs did not report Health Home Core Set measures for FFY 2021: Delaware Assertive Community Integration Support Team (ACIST) Health Home and Michigan Care Team.
X = measure was reported by the Health Home program; -- = measure was not reported by the Health Home program.

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Quality Measures						
Controlling High Blood Pressure	Percentage who had a Diagnosis of Hypertension and Whose Blood Pressure was Adequately Controlled During the Measurement Year: Total (Ages 18 to 85)	15	41.8	41.7	20.5	61.7
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 7 Days of the ED Visit: Ages 18 to 64	18	30.8	29.1	17.4	38.5
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)	18	30.4	28.3	17.5	36.6
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 30 Days of the ED Visit: Ages 18 to 64	18	41.5	39.2	28.3	48.3
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	40.9	38.6	27.5	48.3
Follow-Up After Hospitalization for Mental Illness	Percentage of Discharges for Health Home Enrollees Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days after Discharge: Ages 18 to 64	22	44.7	43.5	29.5	61.7
Follow-Up After Hospitalization for Mental Illness	Percentage of Discharges for Health Home Enrollees Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days after Discharge: Total (Age 6 and Older)	23	46.0	48.0	29.2	62.1
Follow-Up After Hospitalization for Mental Illness	Percentage of Discharges for Health Home Enrollees Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 18 to 64	22	63.5	68.0	48.7	80.8

Table is continued on the next slide.

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021 (continued)

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Quality Measures (continued)						
Follow-Up After Hospitalization for Mental Illness	Percentage of Discharges for Health Home Enrollees Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Total (Age 6 and Older)	24	64.0	66.5	50.7	81.6
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	25	51.7	44.1	36.3	64.0
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 Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Total (Age 13 and Older)	26	51.6	44.7	36.2	64.2
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	21	20.6	16.0	10.8	22.0
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)	21	20.3	15.6	10.8	21.8
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	24	44.1	41.3	28.9	54.4
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 Oral Naltrexone during the measurement year	16	4.9	3.5	1.0	4.9
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	20	29.2	24.5	18.9	34.7
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	25	65.6	63.8	54.5	79.6

Table is continued on the next slide.

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021 (continued)

Measure Name	Rate Definition	Number of Programs Reporting Using Core Set Specifications	Mean	Median	Bottom Quartile	Top Quartile
Quality Measures (continued)						
Plan All-Cause Readmissions	Ratio of Observed All-Cause Readmissions to Expected Readmissions: Ages 18 to 64 [Lower rates are better]	15	1.0027	1.0231	1.2927	0.7991
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]	20	182.7	167.7	226.0	95.2
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]	21	183.9	159.4	232.6	114.7
Utilization Measures						
Admission to an Institution from the Community	Short-Term Stays per 1,000 Enrollee Months: Total (Age 18 and Older)	15	9.4	1.6	0.4	4.7
Ambulatory Care: Emergency Department (ED) Visits	Emergency Department Visits per 1,000 Enrollee Months: Ages 0 to 17 [Lower rates are better]	23	60.5	58.7	69.1	44.6
Ambulatory Care: Emergency Department (ED) Visits	Emergency Department Visits per 1,000 Enrollee Months: Ages 18 to 64 [Lower rates are better]	32	141.8	123.7	157.3	73.7
Ambulatory Care: Emergency Department (ED) Visits	Emergency Department Visits per 1,000 Enrollee Months: Age 65 and older [Lower rates are better]	26	73.5	63.9	81.4	43.9
Ambulatory Care: Emergency Department (ED) Visits	Emergency Department Visits per 1,000 Enrollee Months: Total (All Ages) [Lower rates are better]	33	121.9	103.1	144.5	69.1

Table is continued on the next slide.

Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2021 (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	23	118.0	64.1	14.0	172.8
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Ages 18 to 64	30	197.6	153.4	106.9	322.0
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Ages 65 and Older	24	340.9	196.7	110.3	343.0
Inpatient Utilization	Inpatient Days per 1,000 Enrollee Months: Total (All Ages)	31	211.0	157.3	110.1	309.1
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 0 to 17	23	17.5	8.7	2.1	17.1
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 18 to 64	30	28.1	26.8	20.3	37.3
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Ages 65 and Older	23	32.7	27.4	17.7	44.3
Inpatient Utilization	Inpatient Discharges per 1,000 Enrollee Months: Total (All Ages)	31	31.1	25.0	15.8	37.5
Inpatient Utilization	Inpatient Average Length of Stay: Ages 0 to 17	21	7.7	7.8	3.9	10.3
Inpatient Utilization	Inpatient Average Length of Stay: Ages 18 to 64	28	7.2	6.8	5.2	7.6
Inpatient Utilization	Inpatient Average Length of Stay: Ages 65 and Older	22	8.5	7.3	5.5	12.0
Inpatient Utilization	Inpatient Average Length of Stay: Total (All Ages)	31	7.5	7.0	5.3	9.3

Source: Mathematica analysis of QMR reports for the FFY 2021 reporting cycle as of June 9, 2023.
Notes: This table includes measures that were reported by at least 15 approved Health Home programs for FFY 2021 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 2021. 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.

Acronyms

AOD	Alcohol and Other Drug
AIDS	Acquired Immunodeficiency Disorder
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
NA	Not Applicable
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
QMR	Quality Measure Reporting

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.

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