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# Quality of Care for Children and Adults Enrolled in Medicaid Health Homes: Findings from the 2022 Health Home Core Set

## Chart Pack

March 2024

*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, and led by Mathematica. This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.*

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# About the 2022 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] The 2022 Health Home Core Set includes 13 measures.[3]

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[4]
- 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.[5]

**10**

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, and all territories
[2] https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-mar-2023.pdf
[3] Two measures were added to the 2022 Health Home Core Set. Information about the updates to the 2022 Core Sets is available at https://www.medicaid.gov/sites/default/files/2021-12/cib121021_0.pdf
[4] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf
[5] §1945(g) of the Social Security Act

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# About the 2022 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) 2022, which generally covers care delivered in calendar year 2021. 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.[6] The Chart Pack includes a detailed analysis of Health Home program reporting on 12 publicly reported measures.

For most measures, the performance reflects services provided in calendar year 2021, which was during the COVID-19 pandemic. Due to substantial disruptions in health care during calendar years 2020 and 2021, this Chart Pack does not compare performance reported by programs for FFY 2022 with performance reported for prior years.

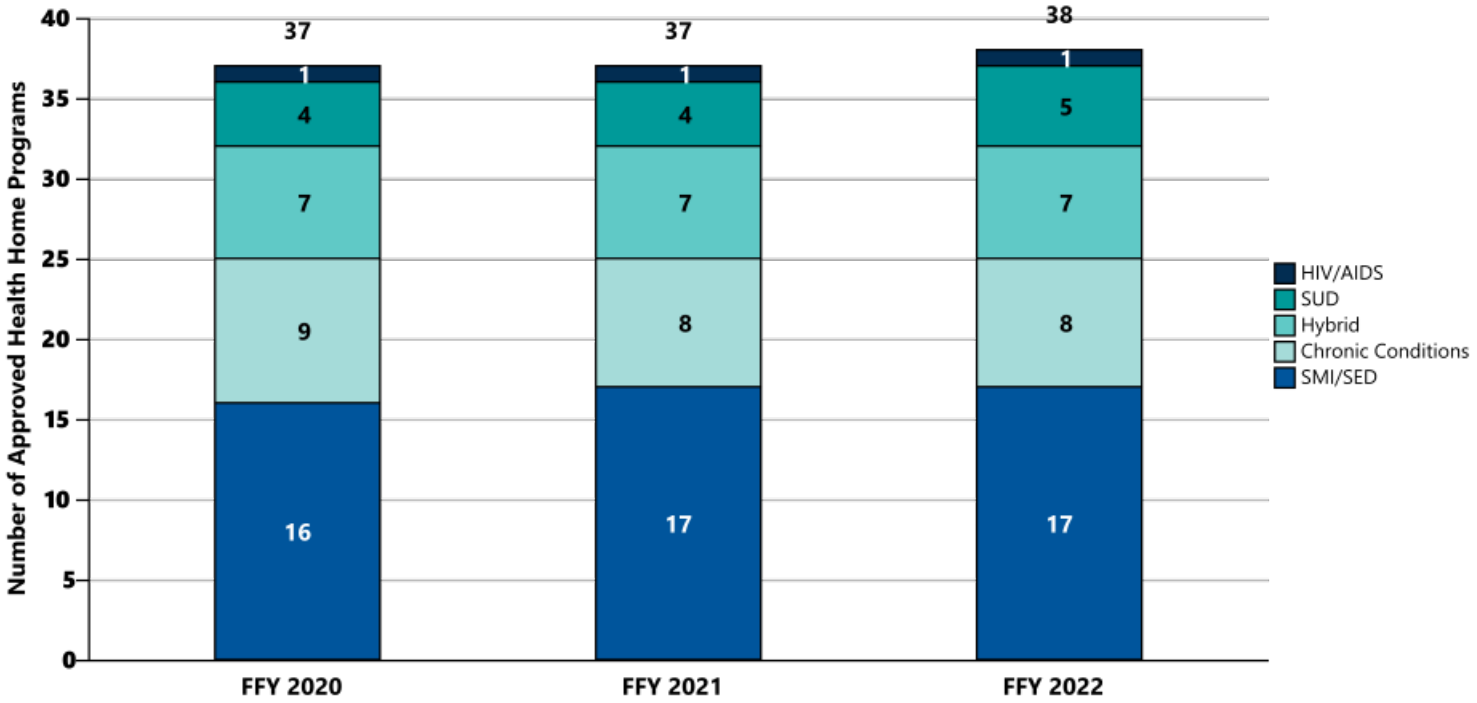
More information about the Health Home Core Set, including the measure performance tables, is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

[6] 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 State rates were excluded because data cannot be displayed per the CMS cell-size suppression policy, which prohibits the direct reporting of data for beneficiary and record counts of 1 to 10 and values from which users can derive values of 1 to 10

# OVERVIEW OF REPORTING OF THE 2022 HEALTH HOME CORE SET BY APPROVED HEALTH HOME PROGRAMS

# Number of Approved Health Home Programs by Target Conditions, FFY 2020–FFY 2022

Approved Health Home programs may focus on different conditions. In FFY 2022, 38 approved Health Home programs served beneficiaries with serious mental illness/severe emotional disturbance (SMI/SED), chronic medical conditions, substance use disorders (SUD), HIV/AIDS, or a combination of these conditions.

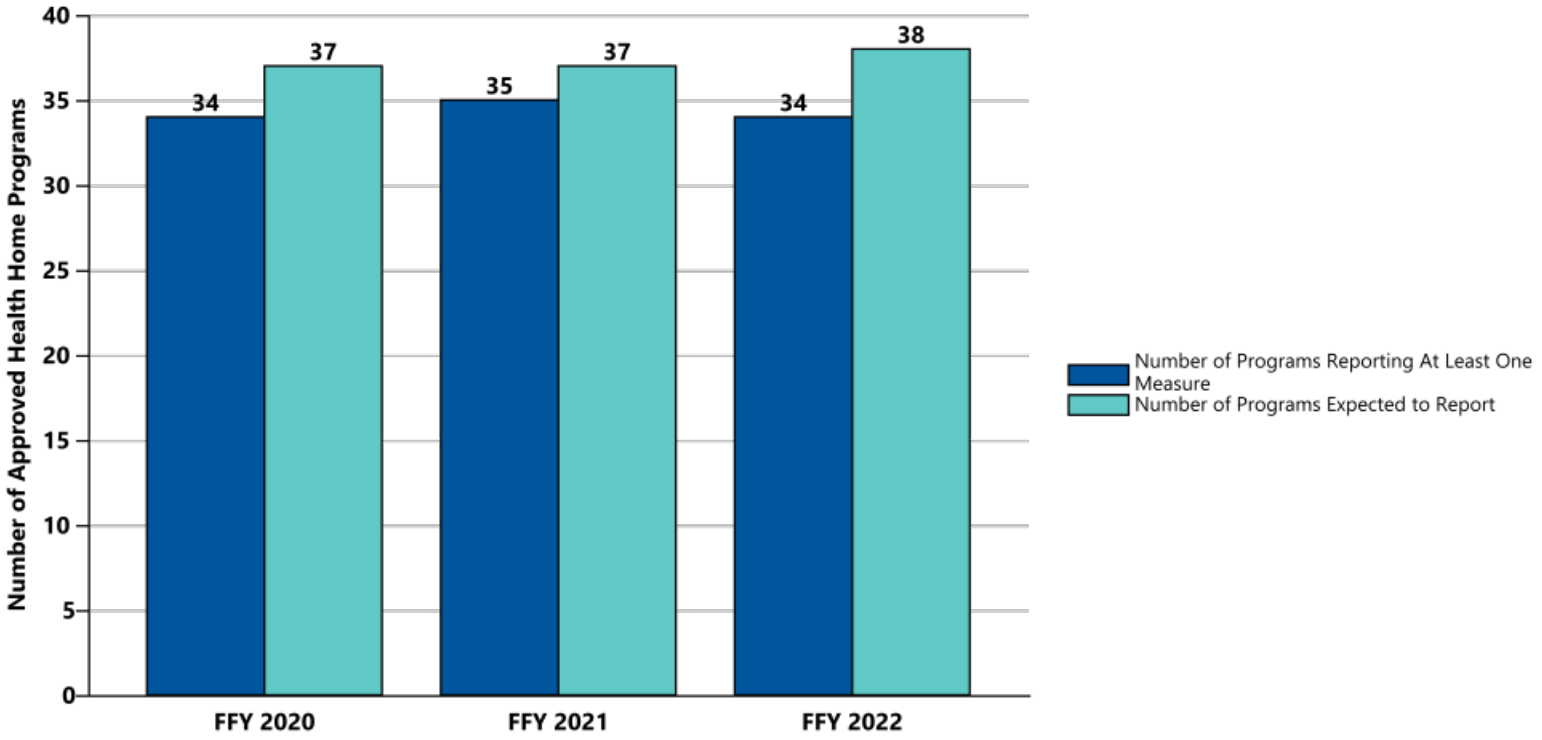



Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, March 2023.

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 2021 Health Home Chart Pack.

# Summary of Health Home Core Set Reporting, FFY 2020–FFY 2022

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 2020 to FFY 2022, the number of programs reporting at least one Health Home Core Set measure has increased or remained consistent. Of the 38 approved Health Home programs expected to report for FFY 2022, 34 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 2020 MACPro reports and FFY 2021 and 2022 QMR system reports.

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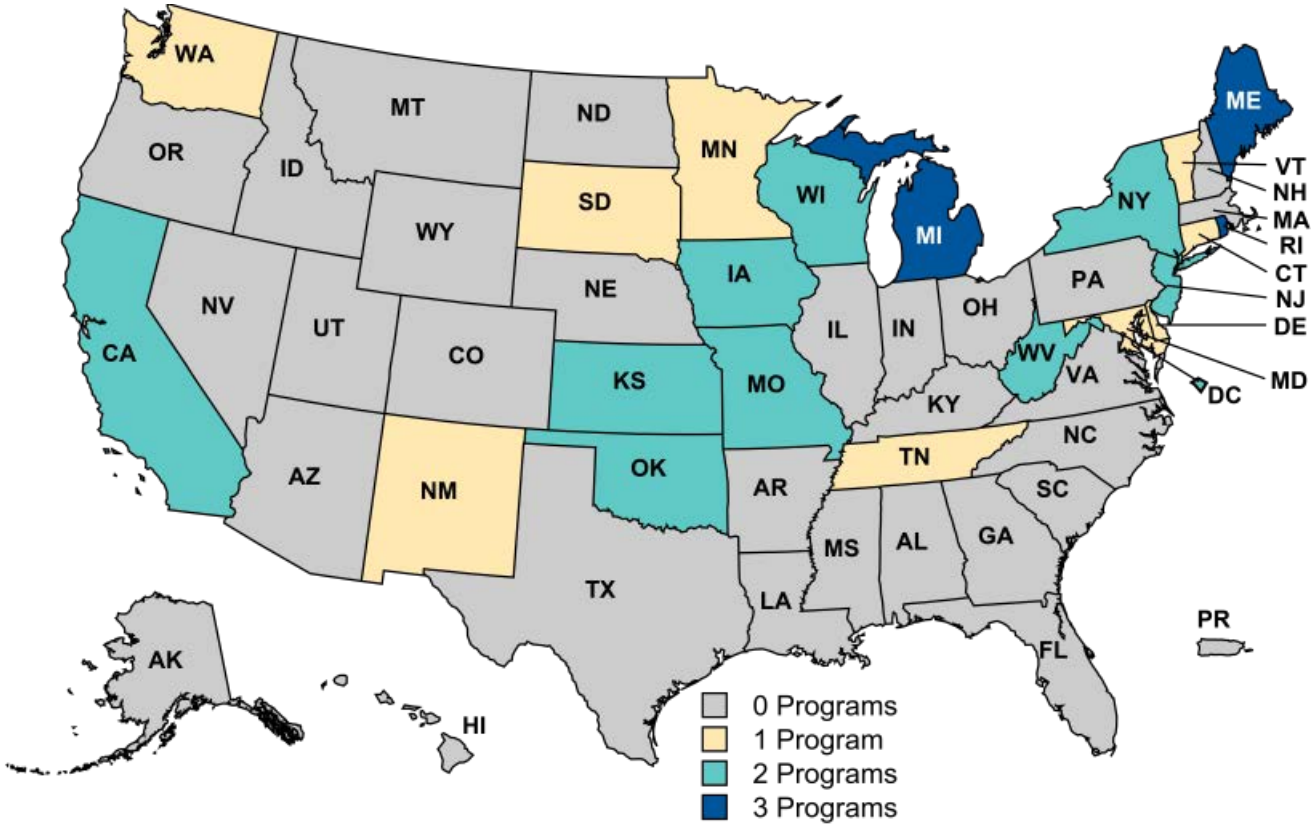
# Geographic Variation in Health Home Programs Expected* to Report Health Home Core Set Measures, FFY 2022




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 2022.

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

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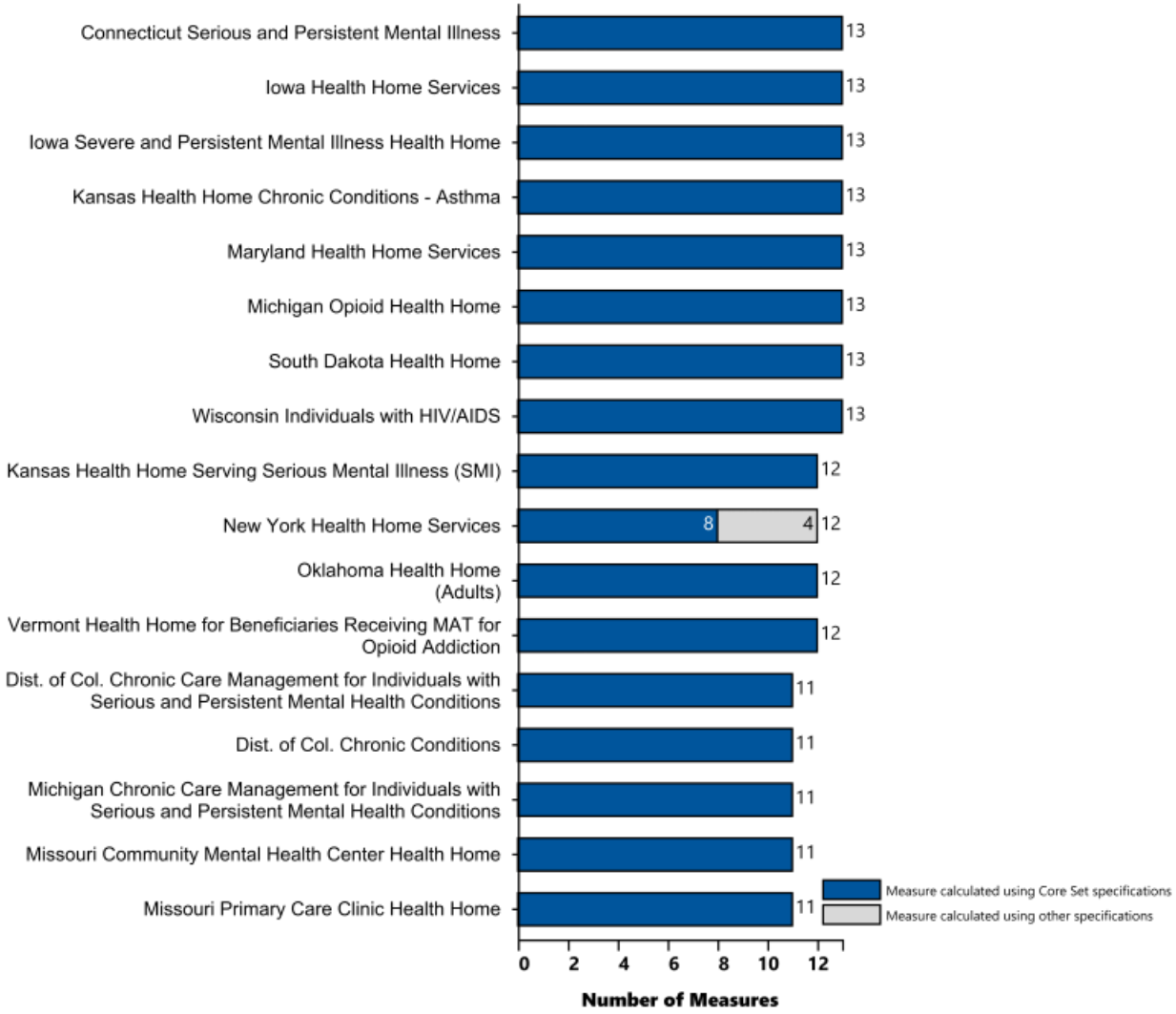
# Number of Health Home Core Set Measures Reported for Approved Health Home Programs, FFY 2022




Health Home programs reported a median of

**10.5**

Health Home Core Set measures for FFY 2022

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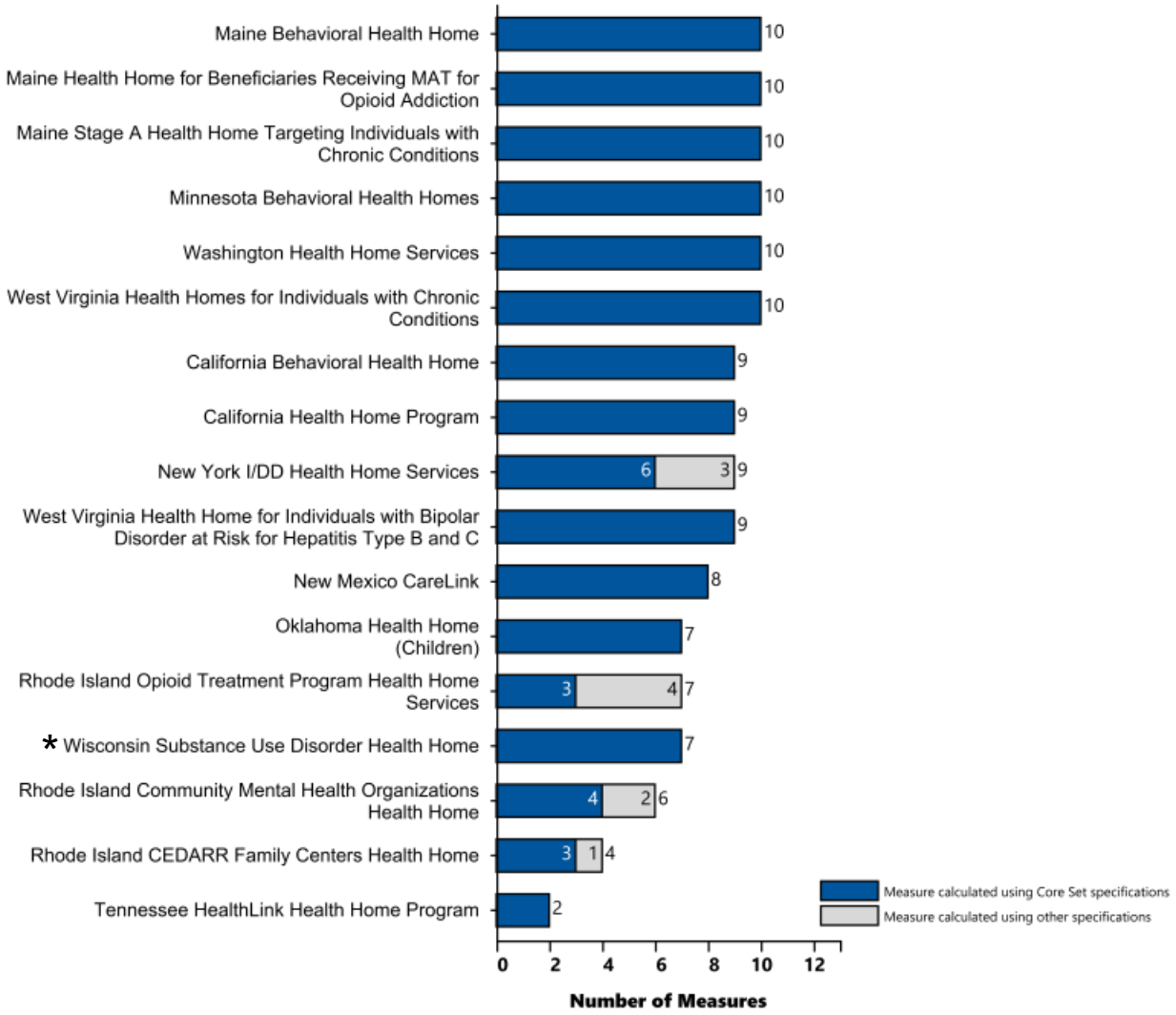
# Number of Health Home Core Set Measures Reported for Approved Health Home Programs, FFY 2022 (continued)

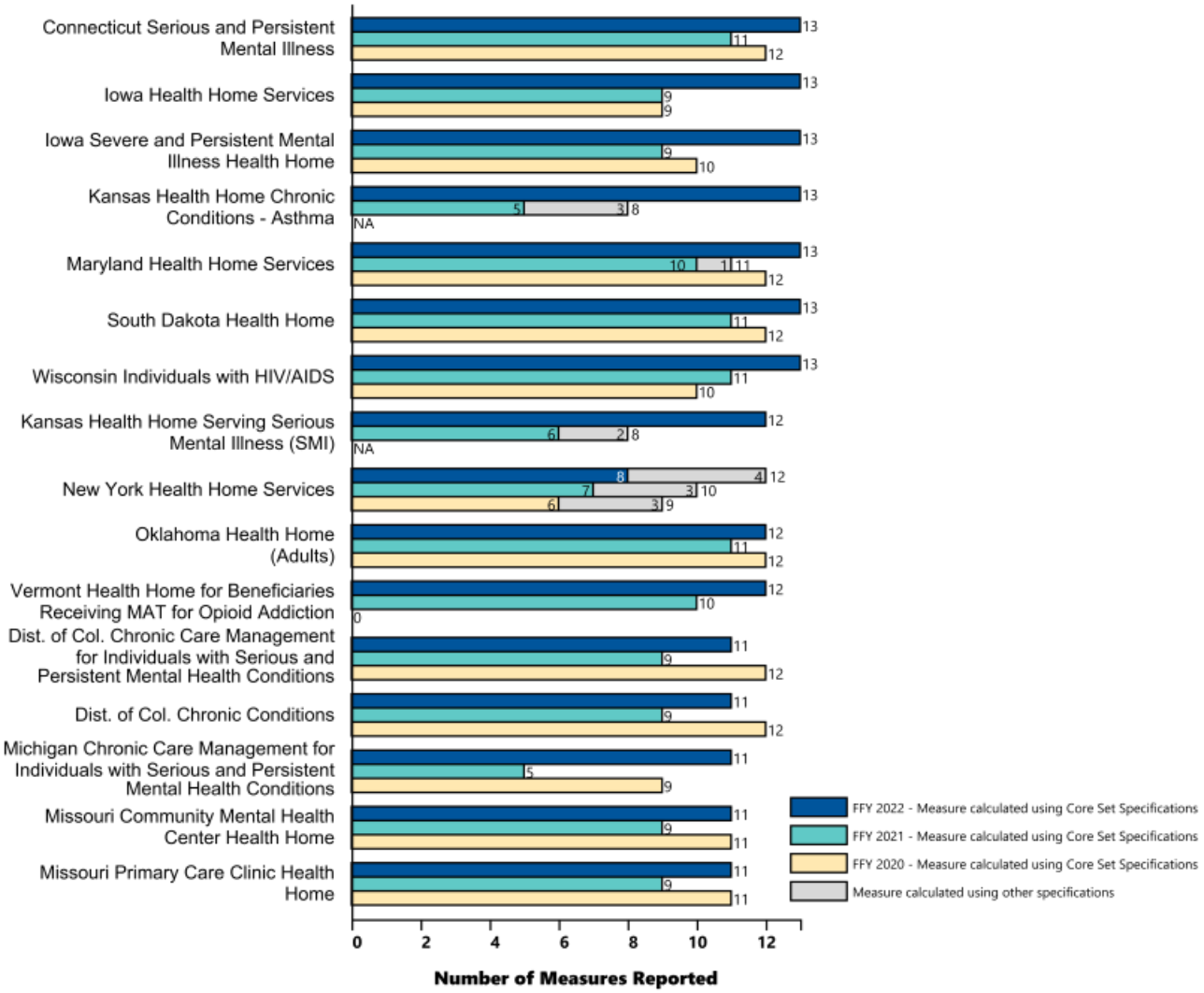



Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Notes: The FFY 2022 Health Home Core Set includes 13 measures. * = State was expected to report for the Health Home program for the first time for the FFY 2022 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). The Delaware Assertive Community Integration Support Team program, Michigan Care Team program, New Jersey Behavioral Health Home (Adults), and New Jersey Behavioral Health Home (Children) are not included, because they did not report data for FFY 2022 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; I/DD = Intellectual/Developmental Disabilities; MAT = Medication Assisted Treatment

# Number of Health Home Core Set Measures Reported for Health Home Programs, FFY 2020–FFY 2022




Reporting remained consistent or increased for

**23**

of the 30 approved Health Home programs that reported for all three years from FFY 2020 to FFY 2022

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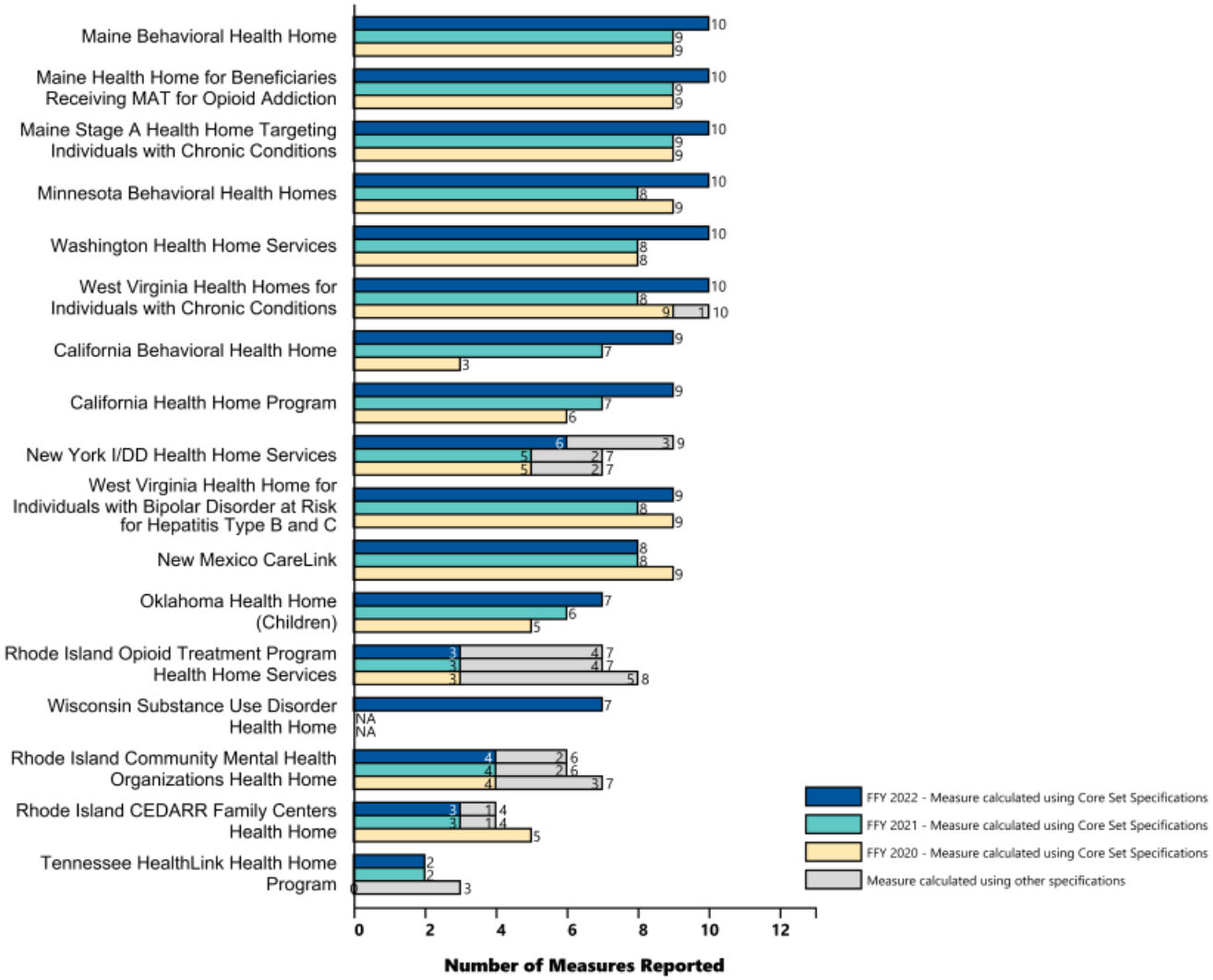
# Number of Health Home Core Set Measures Reported for Health Home Programs, FFY 2020–FFY 2022 (continued)




Source: Mathematica analysis of FFY 2020 MACPro reports and QMR system reports for the FFY 2021 and FFY 2022 reporting cycle as of June 9, 2023.

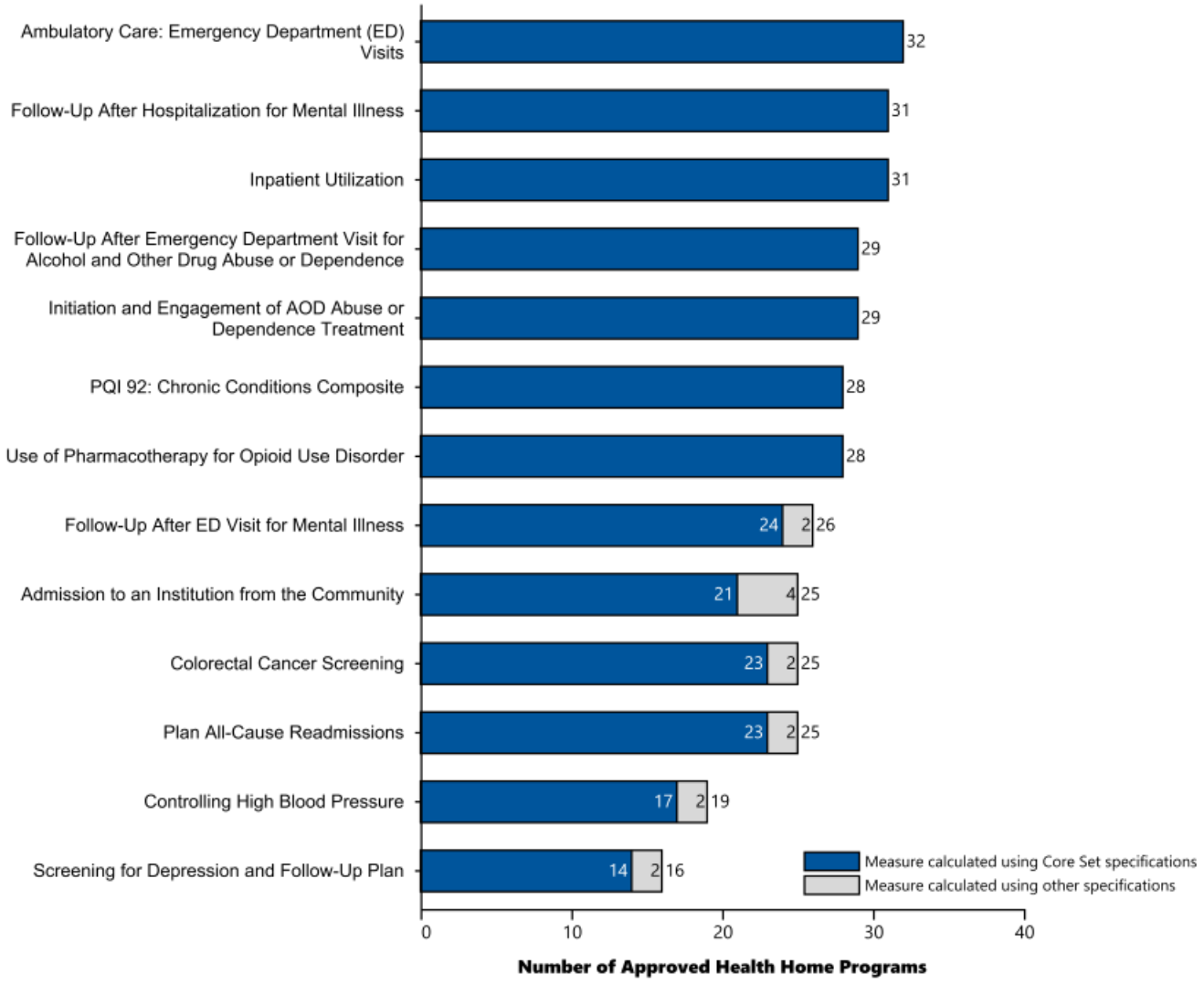
Notes: The 2022 Health Home Core Set includes 13 measures. This is an increase from 11 measures in the 2021 Health Home Core Set. NA = State was not expected to report for the Health Home for the period.

For the purpose of this Chart Pack, "expected" is defined as those 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.

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

# Number of Health Home Programs Reporting the Health Home Core Set Measures, FFY 2022




**11** of the 13 Health Home Core Set measures were reported for at least 20 approved Health Home programs for FFY 2022

Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Notes: The 2022 Health Home Core Set includes 10 quality measures and 3 utilization measures. This chart includes all Health Home Core Set measures that States reported for the FFY 2022 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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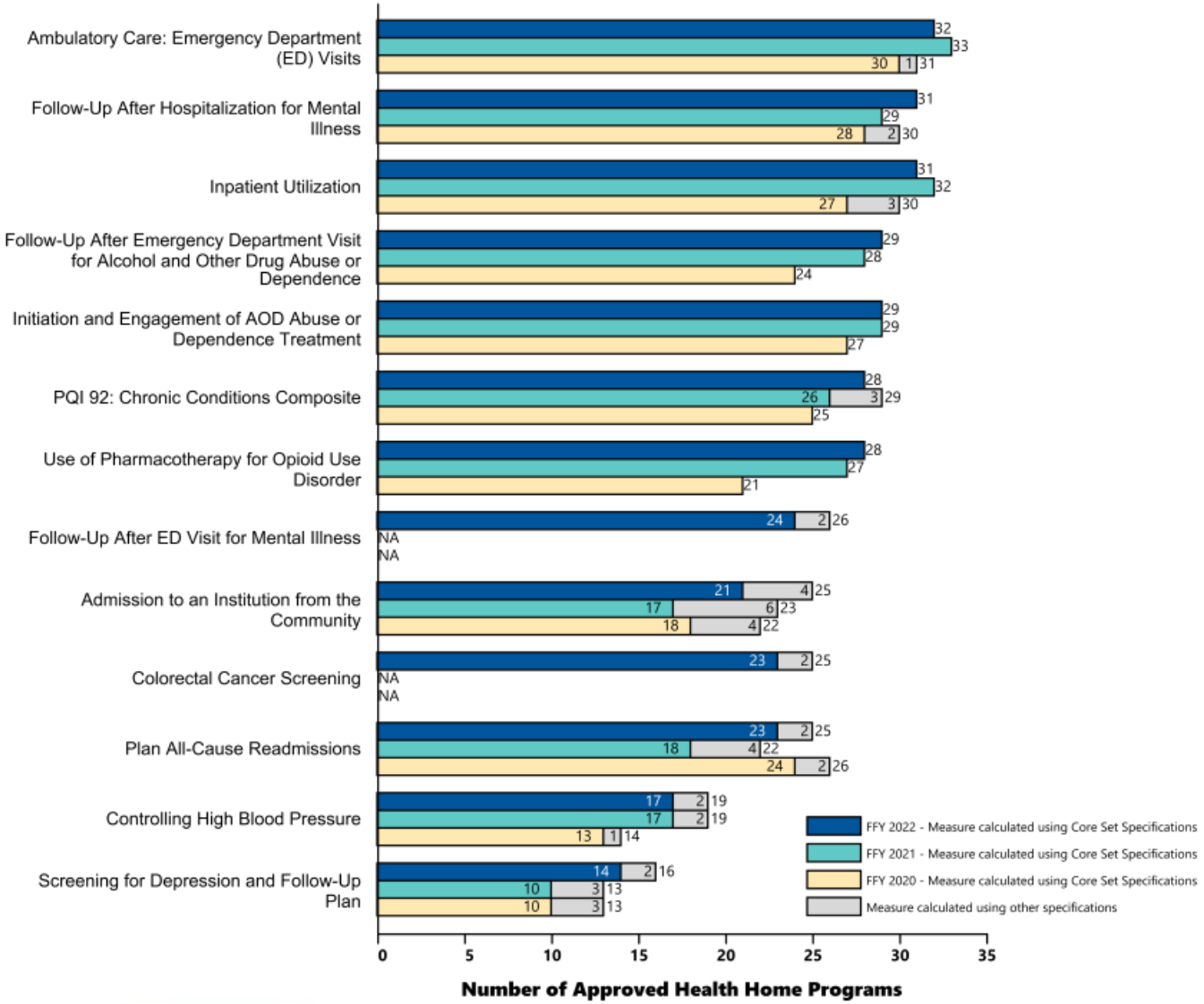
# Number of Health Home Programs Reporting the Health Home Core Set Measures, FFY 2020–FFY 2022




Source: Mathematica analysis of FFY 2020 MACPro reports and QMR system reports for the FFY 2021 and FFY 2022 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: 37 programs for FFY 2020, 37 programs for FFY 2021, and 38 programs for FFY 2022. 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, 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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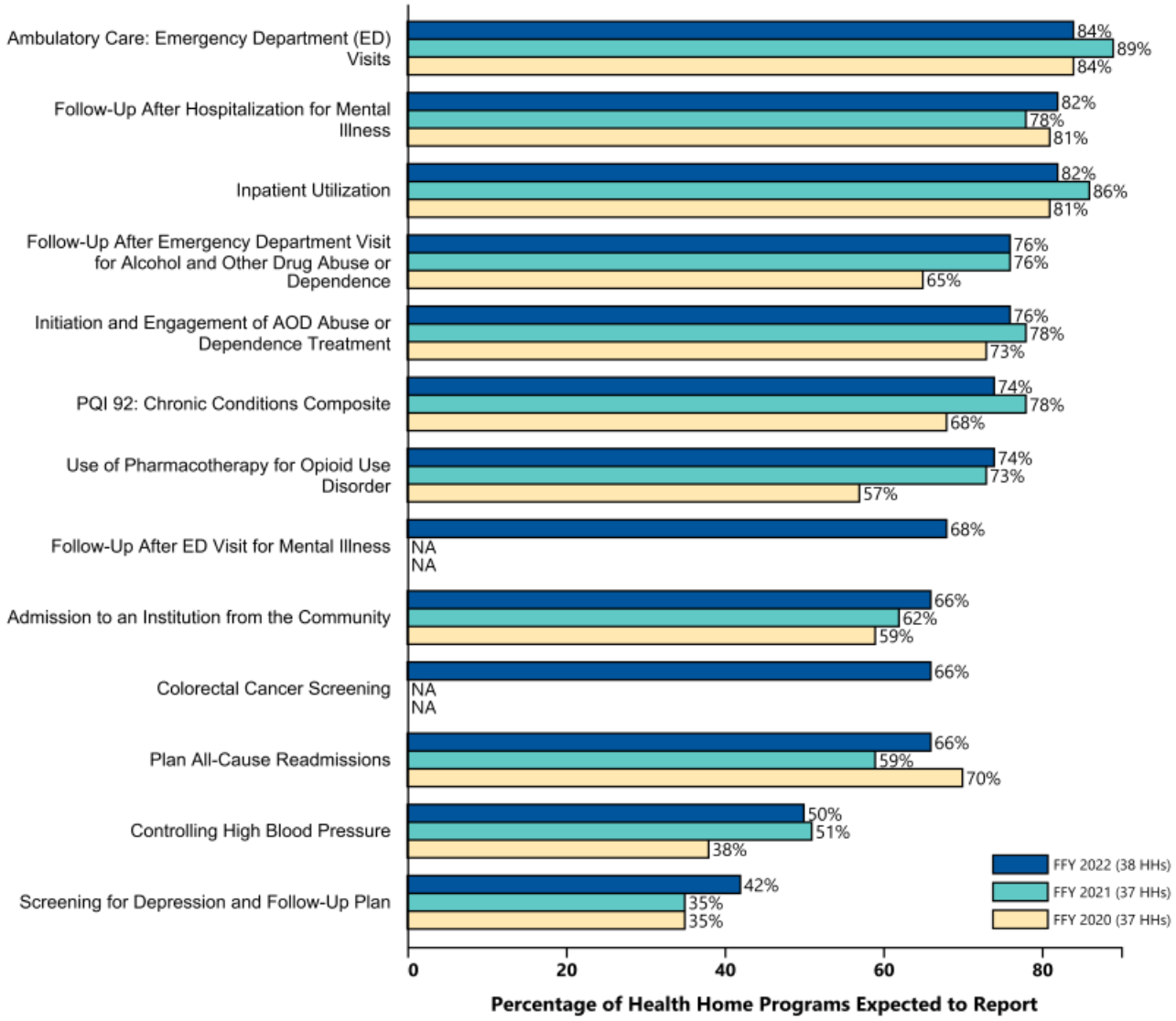
# Percentage of Health Home Programs Reporting Health Home Core Set Measures, FFY 2020–FFY 2022




**11** 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 2020 MACPro reports and QMR system reports for the FFY 2021 and FFY 2022 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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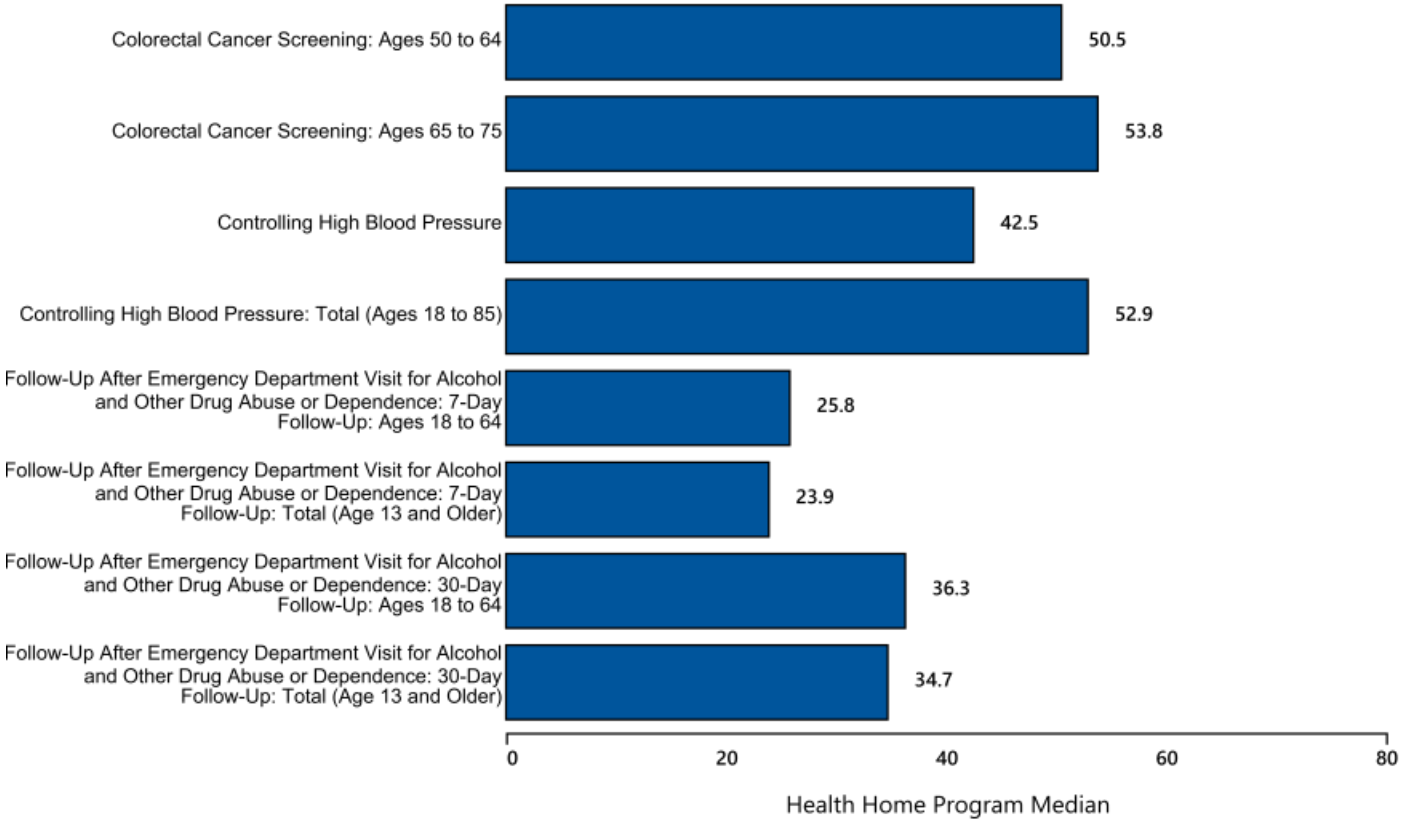
# Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022




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.

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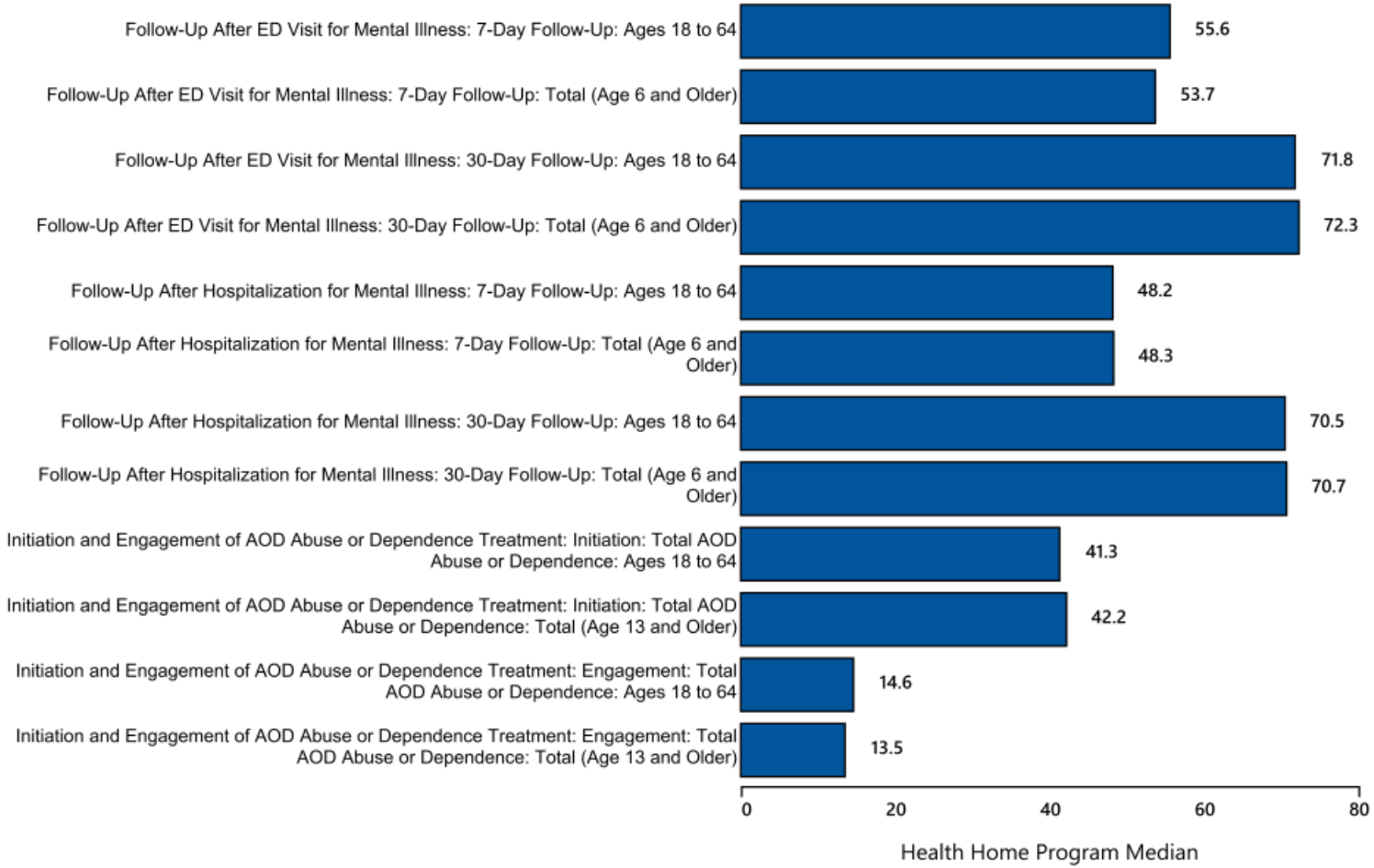
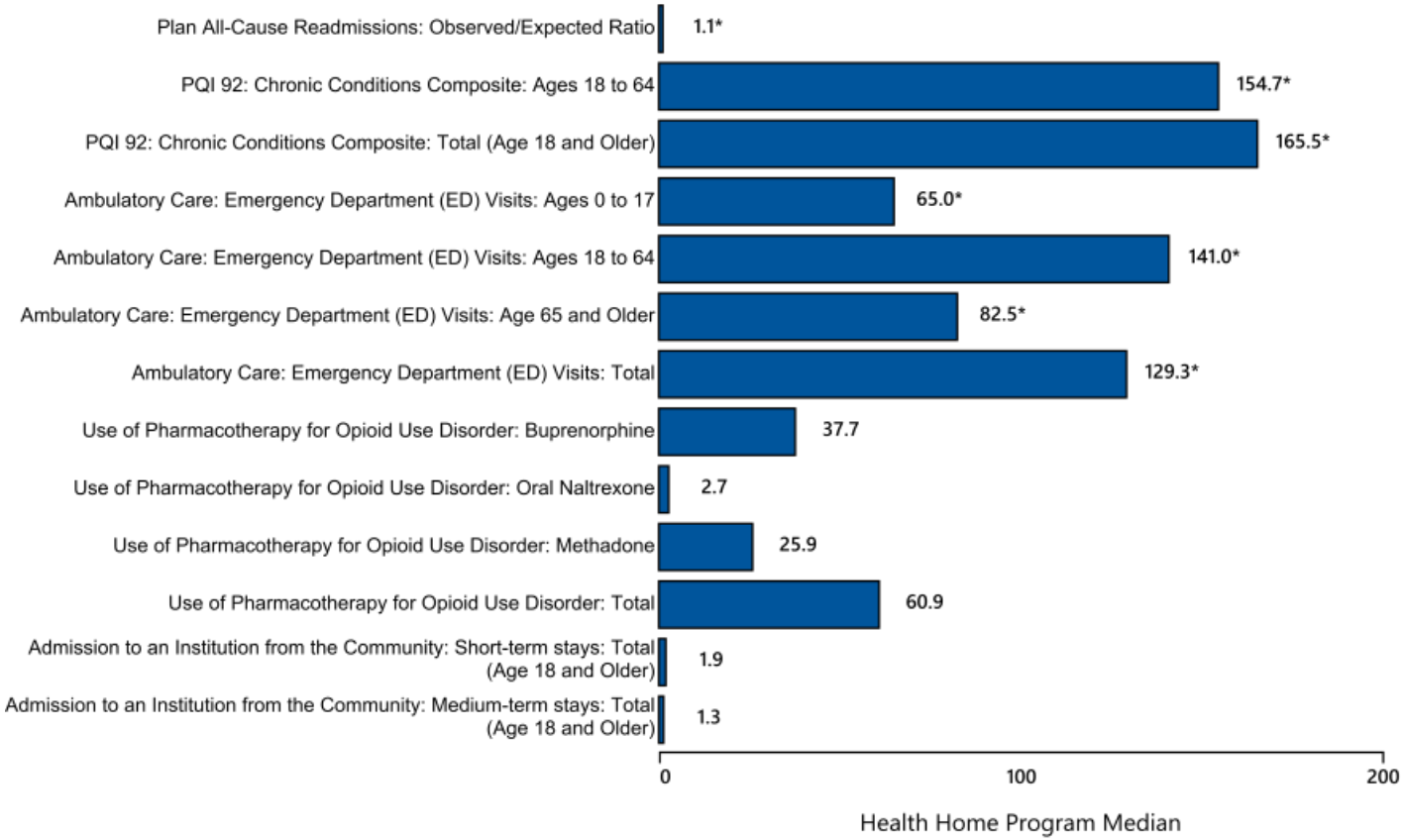
# Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022 (continued)




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 2022 (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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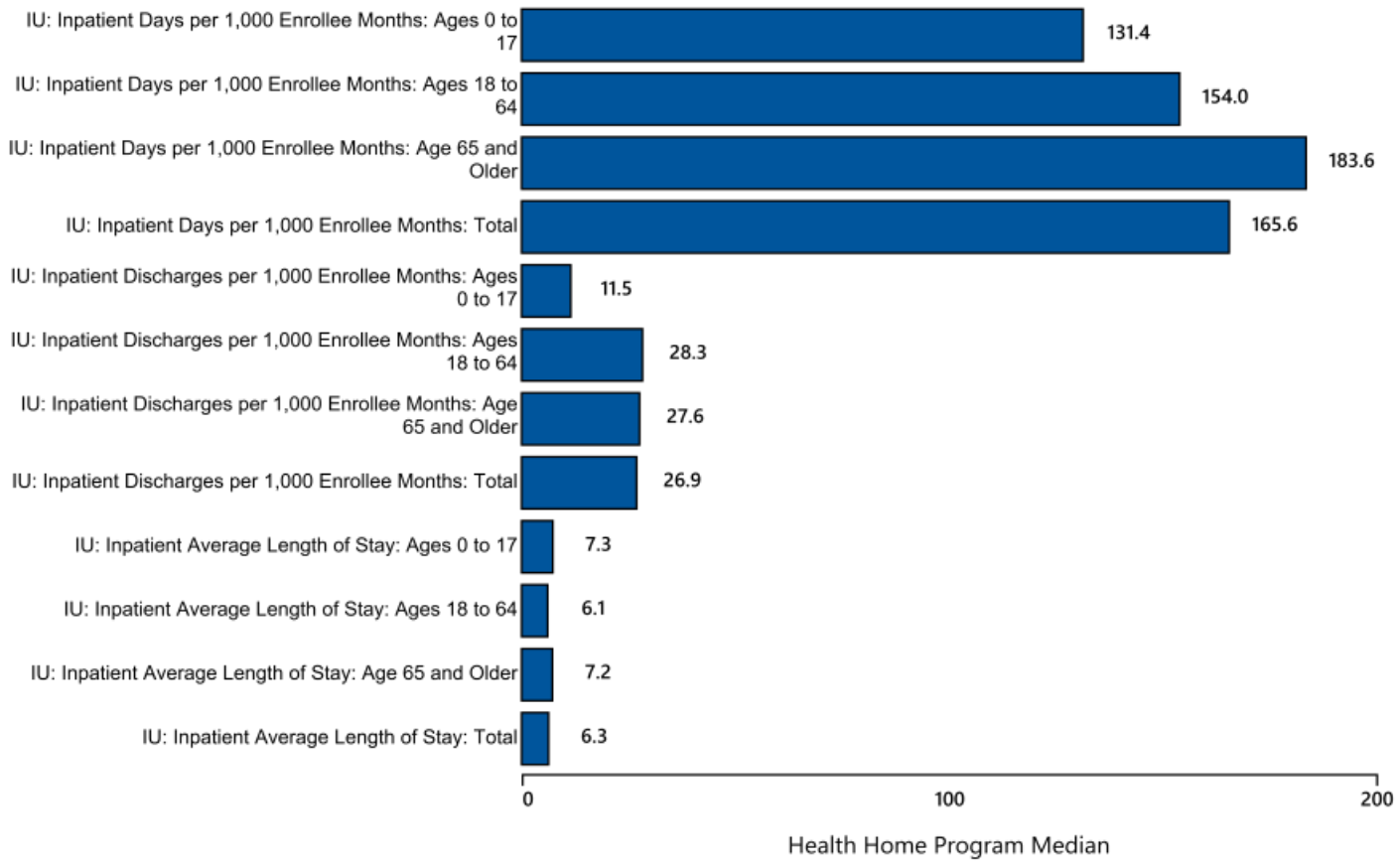
# Median Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022 (continued)




Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Note: This chart includes measures that were reported by at least 15 approved Health Home programs for FFY 2022 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 2022

# Performance Data for Selected FFY 2022 Health Home Core Set Measures

Of the 13 Health Home Core Set measures, 12 were available for performance analysis for FFY 2022. 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.

**Quality Measures**

- Controlling High Blood Pressure
- Colorectal Cancer Screening
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up After Emergency Department Visit 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**

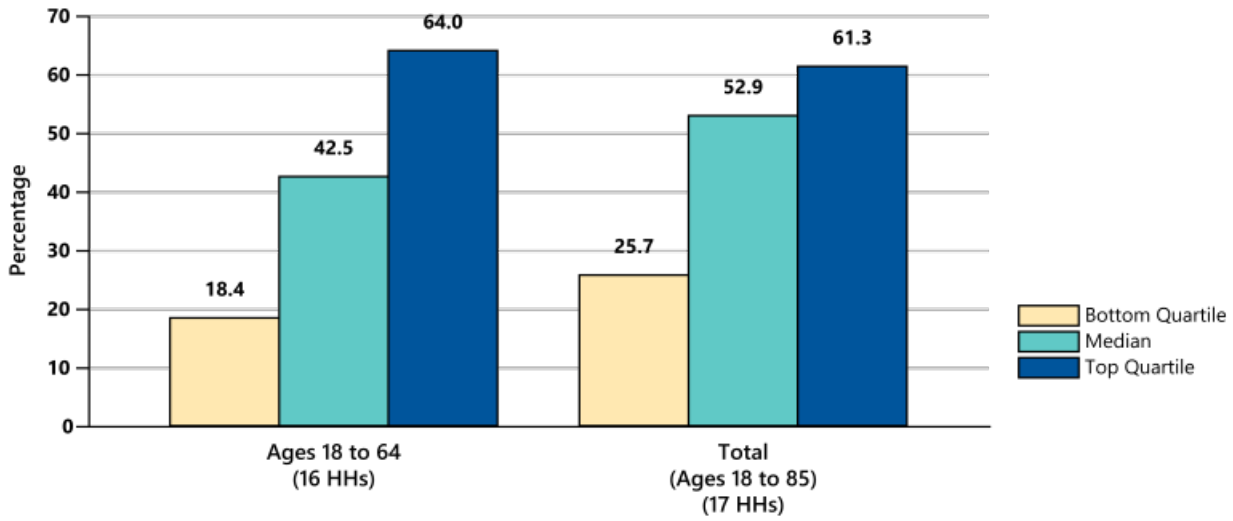
- Admission to an Institution from the Community
- Ambulatory Care: Emergency Department Visits
- Inpatient Utilization

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

# 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.

**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 2022**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Notes: This measure shows the percentage of adults 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. Rate for Ages 65 to 85 are not shown because fewer than 15 Health Home programs reported these rates for FFY 2022. 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.

A median of **53** percent of Health Home enrollees ages 18 to 85 with hypertension had their blood pressure adequately controlled (17 HHs)

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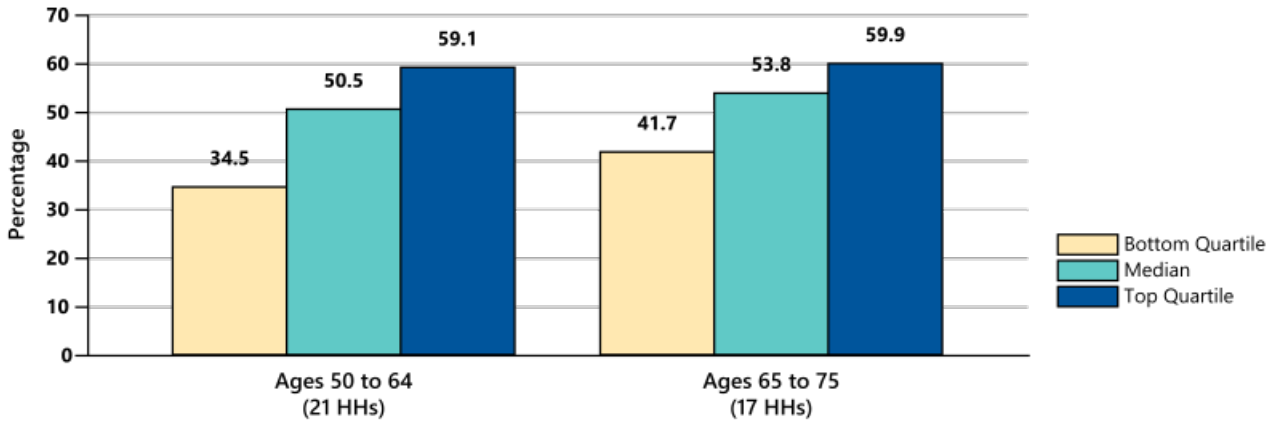
# Colorectal Cancer Screening

The U.S. Preventive Services Task Force recommends screening for colorectal cancer in all adults Ages 50 to 75.* Early detection via colorectal screening and subsequent treatment can reduce colorectal cancer mortality for adults in this age range. This measure shows the percentage of Health Home enrollees Ages 50 to 75 who had an appropriate screening for colorectal cancer. Performance on this measure is being publicly reported for the first time for FFY 2022.

## Percentage of Health Home Enrollees Ages 50 to 75 who had Appropriate Screening for Colorectal Cancer (COL-HH), FFY 2022




Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Notes: This measure shows the percentage of Health Home enrollees Ages 50 to 75 who had an appropriate screening for colorectal cancer. Two rates are reported: (1) the percentage of Health Home enrollees Ages 50 to 64 who had an appropriate screening for colorectal cancer; and (2) the percentage of Health Home enrollees Ages 65 to 75 who had an appropriate screening for colorectal cancer. *In 2021 the US Preventive Services Task Force updated their recommendation for screening for colorectal cancer to include all adults Ages 45 to 75. Subsequent technical specifications for COL-HH reflect this update. 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 Ages 65 to 75, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Ages 65 to 75, MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions for both rates, MI Opioid Health Home for Ages 50 to 64, and WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Ages 65 and 75.

A median of

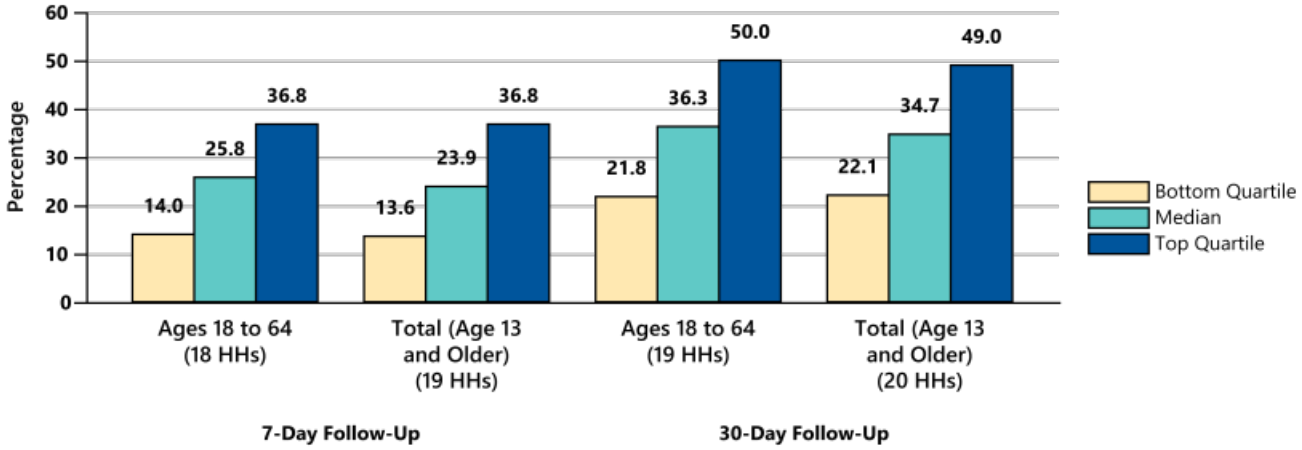
**51** percent of Health Home enrollees ages 50 to 64 (21 HHs) and

**54** percent of Health Home enrollees ages 65 to 75 (17 HHs) had appropriate screening for colorectal cancer.

# 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 2022**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 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. 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 for 7-Day Follow-Up rates, IA Health Home Services, KS Health Home Chronic Conditions – Asthma, KS Health Home Serving Serious Mental Illness (SMI), MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, OK 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 for Ages 18 to 64 for 7-Day and 30-Day Follow-Up rates, WI Individuals with HIV/AIDS, and WI Substance Use Disorder Health Home.

A median of

**24** 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 (19 HHs) and

**35** percent had a follow-up visit within 30 days (20 HHs)

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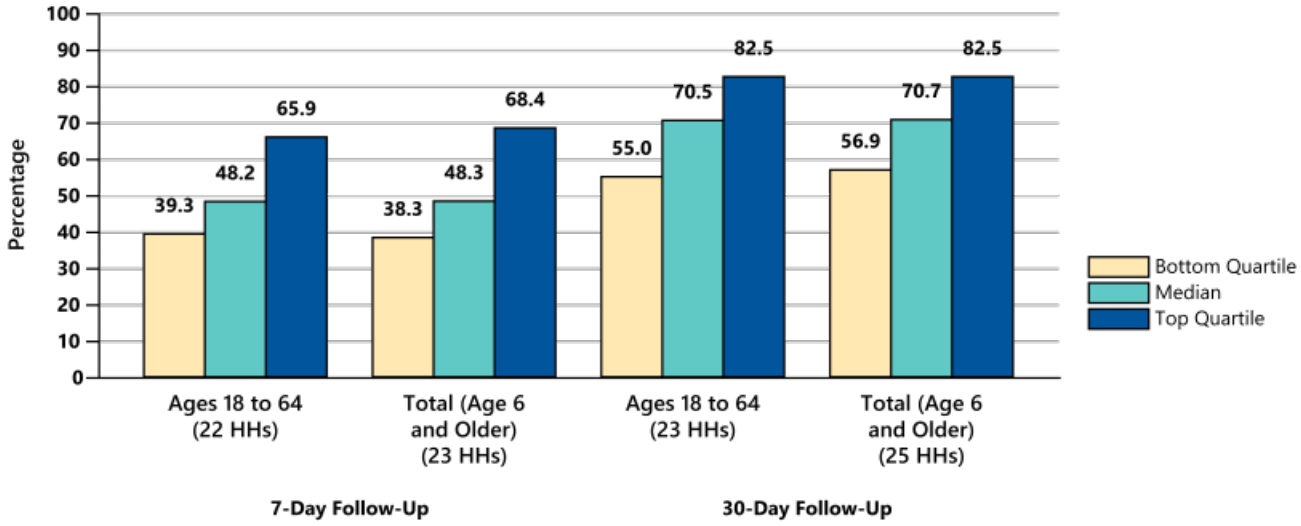
# Follow-Up After Hospitalization for Mental Illness

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 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 2022**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 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 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 2022. 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, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction, WV Health Home for Individuals with Chronic Conditions for the 7-Day Follow-Up rates, WI Individuals with HIV/AIDS, and WI Substance Use Disorder Health Home.

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

**71** percent had a follow-up visit within 30 days after discharge (25 HHs)

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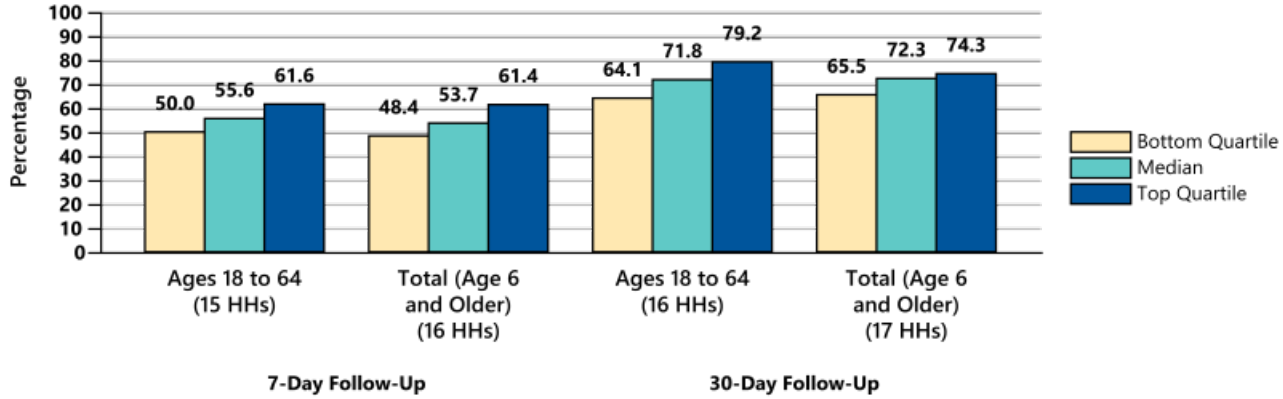
Health Care Quality Measures

# Follow-Up After Emergency Department Visit for Mental Illness

Timely follow-up care after an emergency department (ED) visit for mental illness or intentional self-harm 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 mental health treatment and establishing continuity of care. This measure shows the percentage of beneficiaries who had a follow-up visit with any practitioner within 7 and 30 days of an ED visit for mental illness or intentional self-harm. Performance on this measure is being publicly reported for the first time in FFY 2022.

## Percentage of Emergency Department (ED) Visits for Enrollees Ages 6 and Older who had a Principal Diagnosis of Mental Illness or Intentional Self-Harm with a Follow-Up Visit within 7 Days and 30 Days of the ED Visit (FUM-HH), FFY 2022




Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 1, 2023.

Note: This measure shows the percentage of emergency department (ED) visits for Health Home enrollees Ages 6 and older with a principal diagnosis of mental illness or intentional self-harm that had a follow-up visit for mental illness. Two rates are reported: (1) the percentage of ED visits for which the enrollee received follow-up within 7 days of the ED visit; and (2) the percentage of ED visits for which the enrollee received follow-up within 30 days of the ED visit. 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 2022. This chart excludes NY Health Home Services and NY I/DD 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: DC Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, DC Chronic Conditions, KS Health Home Chronic Conditions – Asthma, MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, MI Opioid Health Home, SD Health Home for the 7-Day Follow-Up rates, WI Individuals with HIV/AIDS, and WI Substance Use Disorder Health Home.

A median of **54** percent of ED visits for Health Home enrollees age 6 and older with mental illness or intentional self-harm diagnoses had a follow-up visit within 7 days (16 HHs) and **72** percent had a follow-up visit within 30 days (17 HHs)

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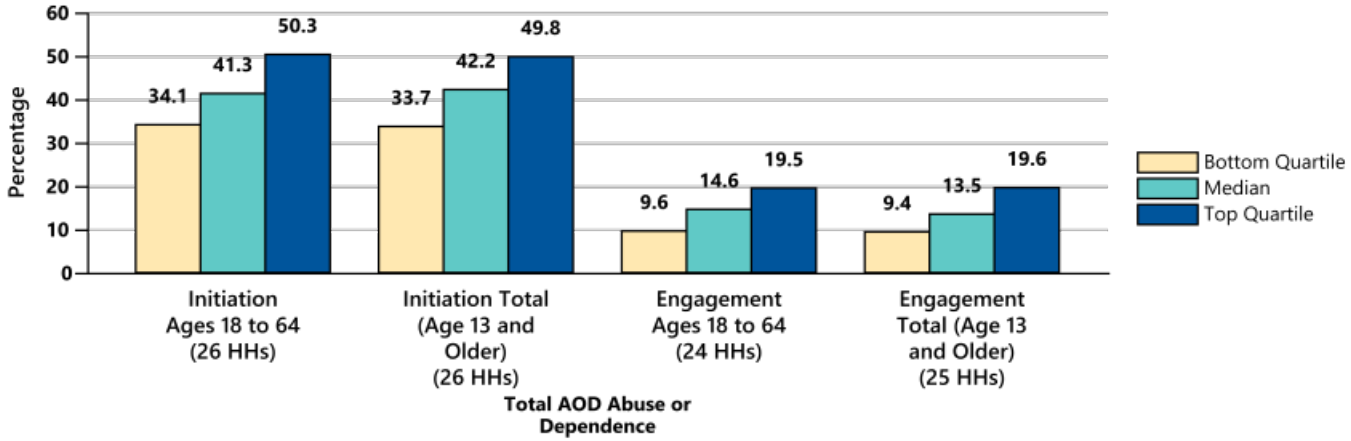
# Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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 2022**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 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 2022. Data were suppressed for the following Health Home programs due to small cell sizes: IA Severe and Persistent Mental Illness for the Engagement rate, KS Health Home Chronic Conditions – Asthma for the Engagement rate, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for the Initiation rate, and OK Health Home (Children) for both rates.

A median of

**42** 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)

A median of

**14** 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.

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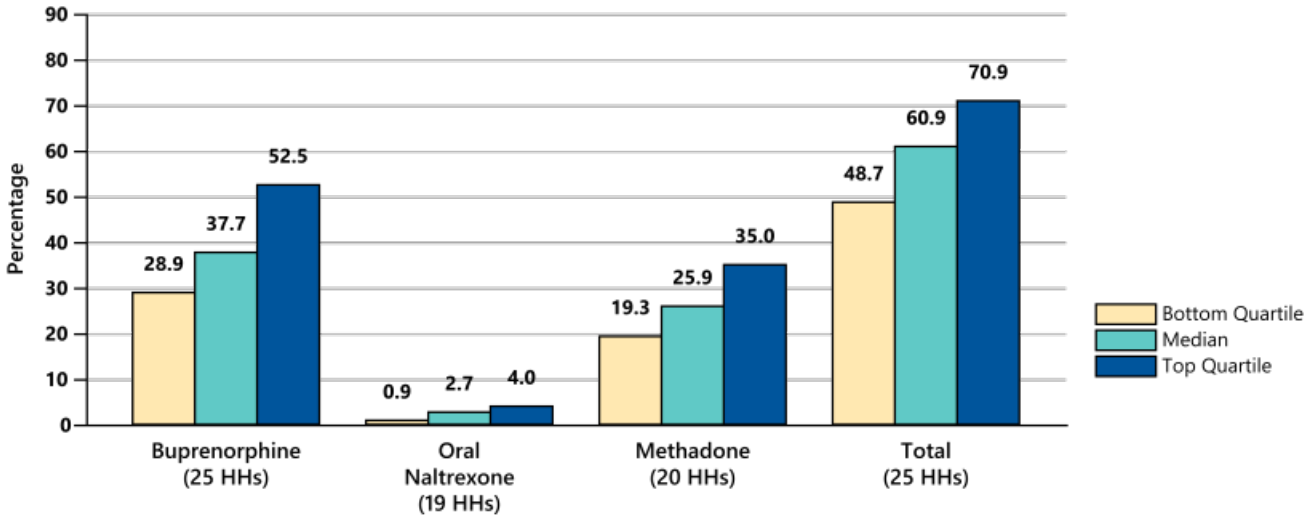
Health Care Quality Measures

# 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 2022




Source: Mathematica analysis of QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Note: 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). Rates for Long-acting Injectable Naltrexone are not shown because fewer than 15 Health Home programs reported these rates for FFY 2022. Data were suppressed for the following Health Home programs due to small cell sizes: DC Chronic Conditions for Oral Naltrexone, IA Health Home Services, KS Health Home Chronic Conditions – Asthma, KS Health Home Serving Serious Mental Illness (SMI) for Oral Naltrexone and Methadone, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Methadone, MI Opioid Health Home for Oral Naltrexone, MO Community Mental Health Center Health Home for Methadone, MO Primary Care Clinic for Oral Naltrexone and Methadone, NM CareLink for Oral Naltrexone, and SD Health Home for Oral Naltrexone and Methadone.

A median of

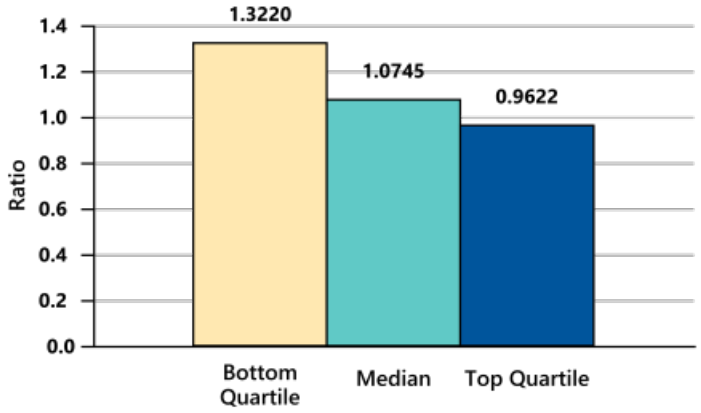
**61**

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 (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 2022 (n = 16 HHs) [Lower rates are better for this measure]**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Note: 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 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, IA Health Home Services, KS Health Home Chronic Conditions – Asthma, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction, MI Opioid Health Home, OK Health Home (Adults), and WI Individuals with HIV/AIDS.

Of the 16 approved Health Home programs reporting the measure,

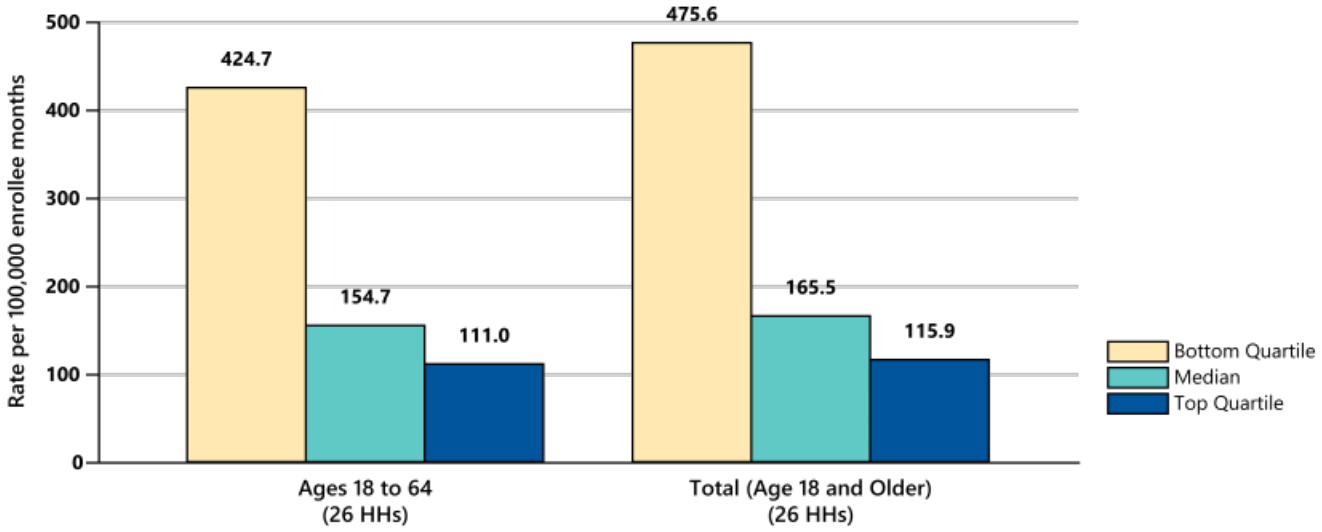
**4**

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 2022 [Lower rates are better for this measure]**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Note: 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 2022. Data were suppressed for the following Health Home programs due to small cell sizes: WI Individuals with HIV/AIDS and WI Substance Use Disorder Health Home.

Health Home enrollees age 18 and older had a median of

**166**

inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months (26 HHs)

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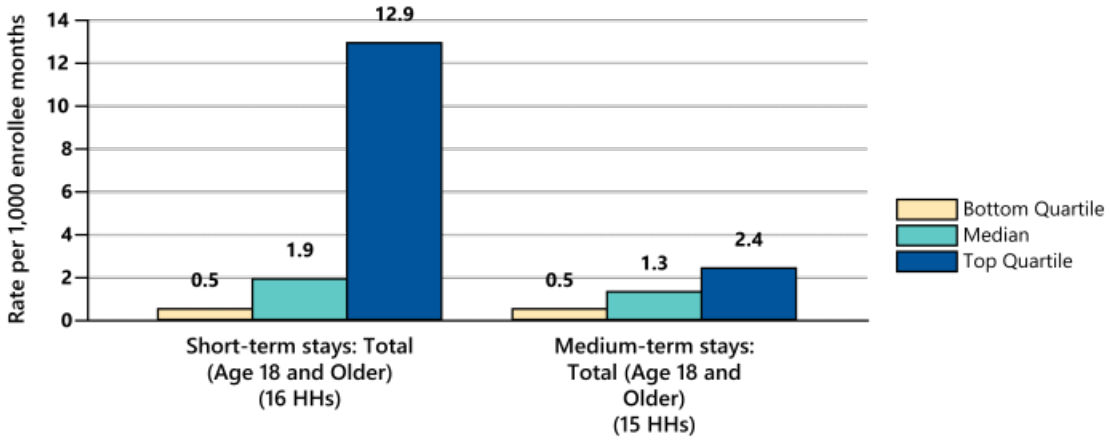
Health Care Quality Measures

# 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- or Medium-Term Stay per 1,000 Enrollee Months for Health Home Enrollees Age 18 and Older (AIF-HH), FFY 2022**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 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 stay rates are not shown because fewer than 15 Health Home programs reported these rates for FFY 2022. This chart excludes the 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: KS Health Home Chronic Conditions – Asthma for medium-term stays, ME Behavioral Health Home for medium-term stays, ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for short-term stays, MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions for short- and medium-term stays, MI Opioid Health Home for short- and medium-term stays, WI Individuals with HIV/AIDS for short- and medium-term stays, and WI Substance Use Disorder Health Home for short- and medium-term stays.

Health Home enrollees age 18 and older had a median of

**1.9**

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

**1.3**

medium-term stays in an institutional facility per 1,000 enrollee months (15 HHs)

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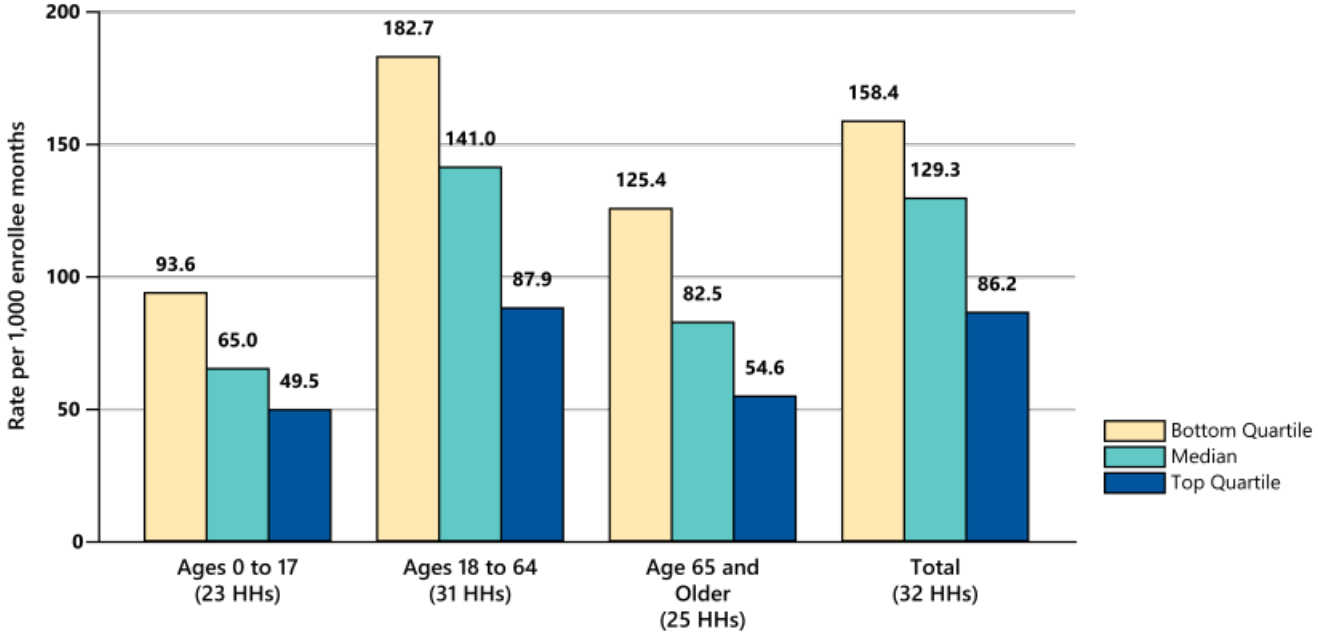
# Ambulatory Care: Emergency Department (ED) Visits

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 2022 [Lower rates are better for this measure]**




Source: Mathematica analysis of the QMR system reports for the FFY 2022 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: ME Health Home for Beneficiaries Receiving MAT for Opioid Addiction for Age 65 and Older, MI Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions for Age 65 and Older, NM CareLink for Age 65 and Older, WV Health Home for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C for Ages 0 to 17, and WI Substance Use Disorder Health Home for Age 65 and Older.

Health Home enrollees had a median of

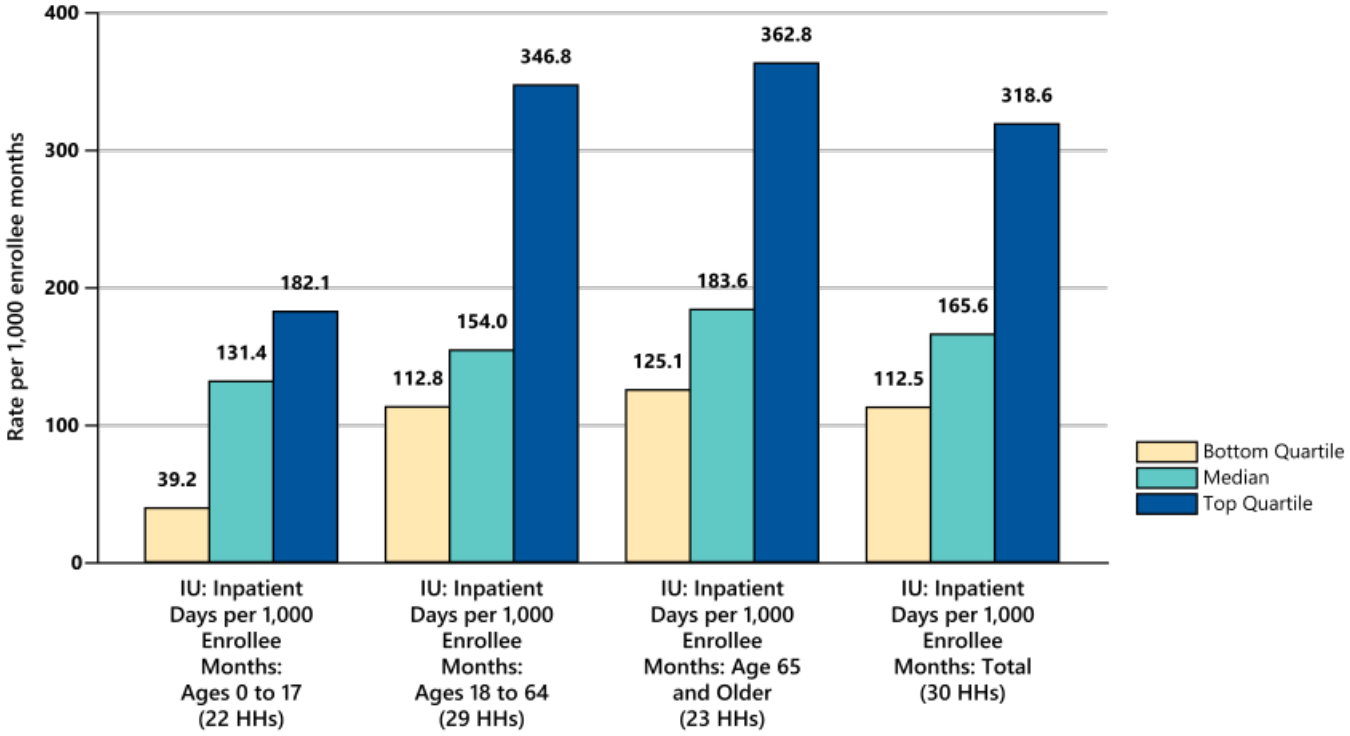
**129**

emergency department visits per 1,000 enrollee months (32 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 2022




Health Home enrollees spent a median of

**166**

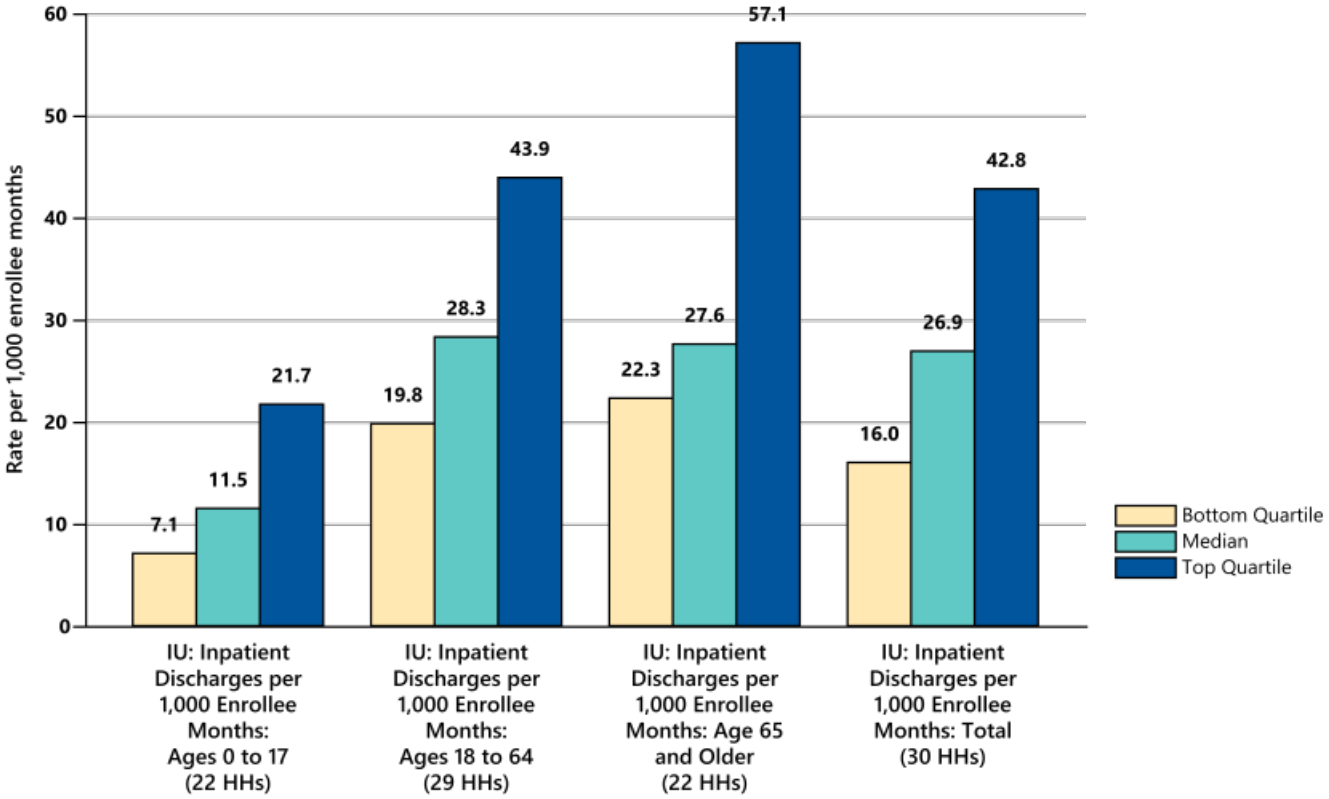
days in the hospital per 1,000 enrollee months (30 HHs)

Source: Mathematica analysis of the QMR system reports for the FFY 2022 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. Data were suppressed for the following Health Home programs due to small cell sizes: 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 Substance Use Disorder Health Home for Age 65 and Older.

# Inpatient Utilization: Inpatient Discharges (continued)

## Discharges from Acute Inpatient Care and Services per 1,000 Enrollee Months for Health Home Enrollees (IU-HH), FFY 2022




Source: Mathematica analysis of the QMR system reports for the FFY 2022 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. Data were suppressed for the following Health Home programs due to small cell sizes: 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, WI Individuals with HIV/AIDS for Age 65 and Older, and WI Substance Use Disorder Health Home for Age 65 and Older.

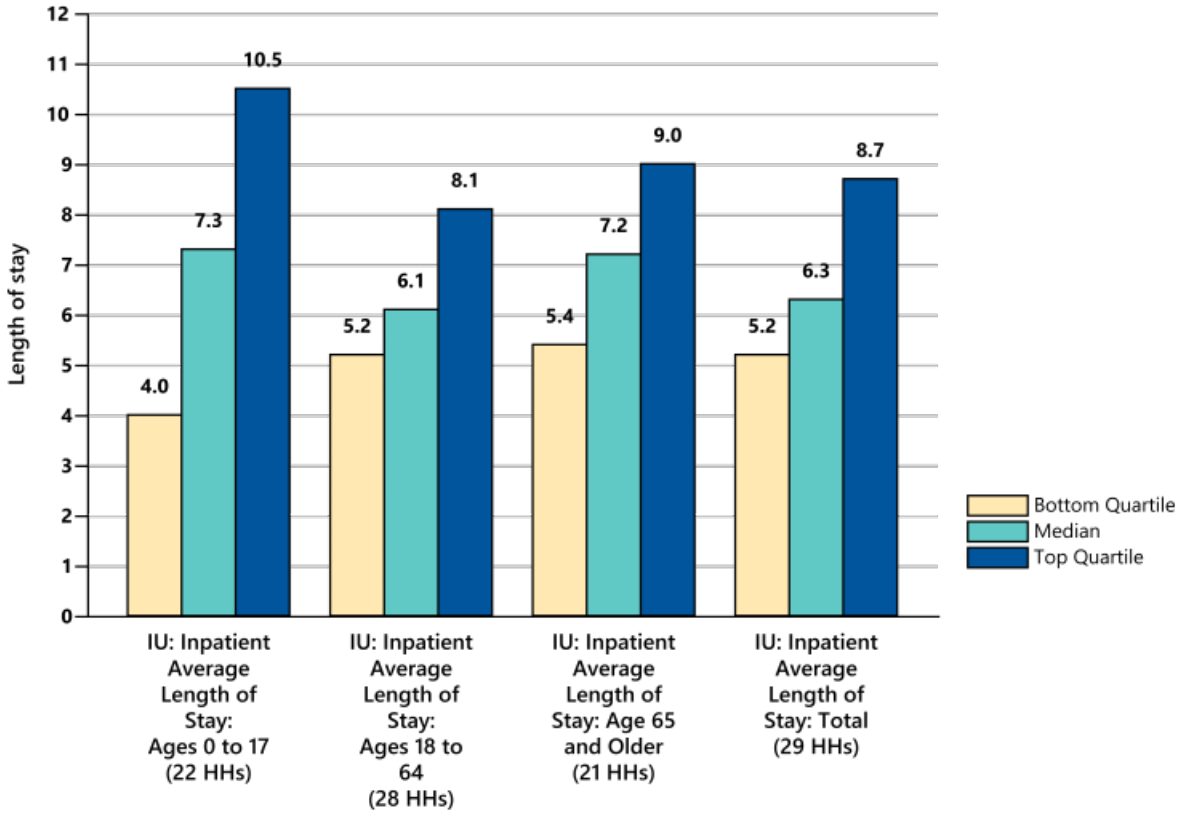
Health Home enrollees had a median of

**27**

inpatient hospital discharges per 1,000 enrollee months (30 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 2022




Source: Mathematica analysis of QMR system reports for the FFY 2022 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. The denominator for length of stay is total discharges. Data were suppressed for the following Health Home programs due to small cell sizes: 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, NY I/DD Health Home Services for Age 65 and Older, RI Opioid Treatment Program Health Home Services for Age 65 and Older, WI Individuals with HIV/AIDS for Age 65 and Older, and WI Substance Use Disorder Health Home for Ages 18 to 64 and Total.

The median length of hospital stays for Health Home enrollees was

**6**

days per discharge (29 HHs)

# REFERENCE TABLES AND ADDITIONAL RESOURCES

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

# Overview of Health Home Program Reporting of the Health Home Core Set Measures, FFY 2022

| | Number of Measures Reported | Controlling High Blood Pressure | Colorectal Cancer Screening | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence | Follow-Up After Hospitalization for Mental Illness | Follow-Up After Emergency Department Visit for Mental Health | 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 | 10.5 (Median) | 19 | 25 | 29 | 31 | 26 | 29 | 28 | 25 | 28 | 16 | 25 | 32 | 31 |
| California Health Home Program | 9 | -- | -- | X | X | X | X | X | X | -- | -- | X | X | X |
| California Behavioral Health Home | 9 | -- | -- | X | X | X | X | X | X | -- | -- | X | X | X |
| Connecticut Serious and Persistent Mental Illness | 13 | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Dist. of Col. Chronic Conditions | 11 | -- | 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 | 11 | -- | X | X | X | X | X | X | X | X | -- | X | X | X |
| Iowa Health Home Services | 13 | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Iowa Severe and Persistent Mental Illness Health Home | 13 | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Kansas Health Home Chronic Conditions - Asthma | 13 | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Kansas Health Home Serving Serious Mental Illness (SMI) | 12 | X | X | X | X | X | X | X | X | X | -- | X | X | X |
| Maine Behavioral Health Home | 10 | -- | X | X | X | -- | X | X | X | X | -- | X | X | X |
| Maine Stage A Health Home Targeting Individuals with Chronic Conditions | 10 | -- | X | X | X | -- | X | X | X | X | -- | X | X | X |
| Maine Health Home for Beneficiaries Receiving MAT for Opioid Addiction | 10 | -- | X | X | X | -- | X | X | X | X | -- | X | X | X |
| Maryland Health Home Services | 13 | X | X | 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 2022 (continued)

| | Number of Measures Reported | Controlling High Blood Pressure | Colorectal Cancer Screening | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence | Follow-Up After Hospitalization for Mental Illness | Follow-Up After Emergency Department Visit for Mental Health | 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 | 11 | X | X | X | X | X | X | -- | -- | X | X | X | X | X |
| Michigan Opioid Health Home | 13 | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Minnesota Behavioral Health Homes | 10 | -- | X | 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 | 8 | -- | -- | X | X | -- | X | X | X | X | -- | -- | X | X |
| New York Health Home Services | 12 | X | X | X | X | X | X | X | -- | X | X | X | X | X |
| New York I/DD Health Home Services | 9 | -- | X | -- | X | X | X | -- | -- | 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) | 7 | -- | -- | X | 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 |
| South Dakota Health Home | 13 | X | X | 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 2022 (continued)

| | Number of Measures Reported | Controlling High Blood Pressure | Colorectal Cancer Screening | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence | Follow-Up After Hospitalization for Mental Illness | Follow-Up After Emergency Department Visit for Mental Health | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tennessee HealthLink Health Home Program | 2 | X | -- | -- | X | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Vermont Health Home for Beneficiaries Receiving MAT for Opioid Addiction | 12 | X | X | X | X | X | X | X | X | X | -- | X | X | X |
| Washington Health Home Services | 10 | -- | X | X | 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 | 13 | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Wisconsin Substance Use Disorder Health Home | 7 | -- | -- | X | X | X | -- | -- | -- | X | -- | X | X | X |

Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 9, 2023.

Notes: The 2022 Health Home Core Set includes 13 measures. The following approved Health Home programs did not report Health Home Core Set measures for FFY 2022 by the reporting deadline: Delaware Assertive Community Integration Support Team (ACIST) Health Home, Michigan Care Team, New Jersey Behavioral Health Home (Adults), and New Jersey Behavioral Health Home (Children).

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 2022

| 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: Ages 18 to 64 | 16 | 41.5 | 42.5 | 18.4 | 64.0 |
| 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) | 17 | 42.4 | 52.9 | 25.7 | 61.3 |
| Colorectal Cancer Screening | Percentage of enrollees ages 50 to 64 who had Appropriate Screening for Colorectal Cancer | 21 | 45.8 | 50.5 | 34.5 | 59.1 |
| Colorectal Cancer Screening | Percentage of enrollees ages 65 to 75 who had Appropriate Screening for Colorectal Cancer | 17 | 47.5 | 53.8 | 41.7 | 59.9 |
| 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 (AOD) Abuse or Dependence with a Follow-Up Visit for AOD Abuse or Dependence Within 7 Days of the ED Visit: Ages 18 to 64 | 18 | 27.6 | 25.8 | 14.0 | 36.8 |
| 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 (AOD) Abuse or Dependence with a Follow-Up Visit for AOD Abuse or Dependence Within 7 Days of the ED Visit: Total (Age 13 and Older) | 19 | 26.9 | 23.9 | 13.6 | 36.8 |
| 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 (AOD) Abuse or Dependence with a Follow-Up Visit for AOD Abuse or Dependence Within 30 Days of the ED Visit: Ages 18 to 64 | 19 | 38.2 | 36.3 | 21.8 | 50.0 |
| 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 (AOD) Abuse or Dependence with a Follow-Up Visit for AOD Abuse or Dependence Within 30 Days of the ED Visit: Total (Age 13 and Older) | 20 | 37.1 | 34.7 | 22.1 | 49.0 |

Table is continued on the next slide.

# Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022 (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 7 Days after Discharge: Ages 18 to 64 | 22 | 49.7 | 48.2 | 39.3 | 65.9 |
| 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 | 50.2 | 48.3 | 38.3 | 68.4 |
| 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 | 23 | 67.2 | 70.5 | 55.0 | 82.5 |
| 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) | 25 | 66.3 | 70.7 | 56.9 | 82.5 |
| Follow-Up After Emergency Department Visit for Mental Illness | Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64 | 15 | 55.4 | 55.6 | 50.0 | 61.6 |
| Follow-Up After Emergency Department Visit for Mental Illness | Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of the ED Visit: Total (Age 6 and Older) | 16 | 55.2 | 53.7 | 48.4 | 61.4 |
| Follow-Up After Emergency Department Visit for Mental Illness | Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64 | 16 | 70.8 | 71.8 | 64.1 | 79.2 |
| Follow-Up After Emergency Department Visit for Mental Illness | Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of the ED Visit: Total (Age 6 and Older) | 17 | 70.7 | 72.3 | 65.5 | 74.3 |

Table is continued on the next slide.

# Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022 (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 | 26 | 47.9 | 41.3 | 34.1 | 50.3 |
| 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) | 26 | 48.0 | 42.2 | 33.7 | 49.8 |
| 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 | 24 | 17.8 | 14.6 | 9.6 | 19.5 |
| 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: Total (Age 13 and Older) | 25 | 16.9 | 13.5 | 9.4 | 19.6 |
| 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 | 25 | 42.0 | 37.7 | 28.9 | 52.5 |
| 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 | 19 | 4.1 | 2.7 | 0.9 | 4.0 |
| 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 | 32.0 | 25.9 | 19.3 | 35.0 |
| 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 | 63.0 | 60.9 | 48.7 | 70.9 |

Table is continued on the next slide.

# Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022 (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] | 16 | 1.1164 | 1.0745 | 1.3220 | 0.9622 |
| 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] | 26 | 362.3 | 154.7 | 424.7 | 111.0 |
| 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] | 26 | 368.5 | 165.5 | 475.6 | 115.9 |
| **Utilization Measures** | | | | | | |
| Admission to an Institution from the Community | Short-Term Stays per 1,000 Enrollee Months: Total (Age 18 and Older) | 16 | 10.3 | 1.9 | 0.5 | 12.9 |
| Admission to an Institution from the Community | Medium-Term Stays per 1,000 Enrollee Months: Total (Age 18 and Older) | 15 | 4.0 | 1.3 | 0.5 | 2.4 |
| Ambulatory Care: Emergency Department (ED) Visits | Emergency Department Visits per 1,000 Enrollee Months: Ages 0 to 17 [Lower rates are better] | 23 | 98.0 | 65.0 | 93.6 | 49.5 |
| Ambulatory Care: Emergency Department (ED) Visits | Emergency Department Visits per 1,000 Enrollee Months: Ages 18 to 64 [Lower rates are better] | 31 | 227.1 | 141.0 | 182.7 | 87.9 |
| Ambulatory Care: Emergency Department (ED) Visits | Emergency Department Visits per 1,000 Enrollee Months: Age 65 and older [Lower rates are better] | 25 | 180.4 | 82.5 | 125.4 | 54.6 |
| Ambulatory Care: Emergency Department (ED) Visits | Emergency Department Visits per 1,000 Enrollee Months: Total (All Ages) [Lower rates are better] | 32 | 204.7 | 129.3 | 158.4 | 86.2 |

Table is continued on the next slide.

# Performance Rates on Frequently Reported Health Home Core Set Measures, FFY 2022 (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 | 22 | 138.7 | 131.4 | 39.2 | 182.1 |
| Inpatient Utilization | Inpatient Days per 1,000 Enrollee Months: Ages 18 to 64 | 29 | 212.8 | 154.0 | 112.8 | 346.8 |
| Inpatient Utilization | Inpatient Days per 1,000 Enrollee Months: Age 65 and Older | 23 | 315.9 | 183.6 | 125.1 | 362.8 |
| Inpatient Utilization | Inpatient Days per 1,000 Enrollee Months: Total (All Ages) | 30 | 215.2 | 165.6 | 112.5 | 318.6 |
| Inpatient Utilization | Inpatient Discharges per 1,000 Enrollee Months: Ages 0 to 17 | 22 | 22.8 | 11.5 | 7.1 | 21.7 |
| Inpatient Utilization | Inpatient Discharges per 1,000 Enrollee Months: Ages 18 to 64 | 29 | 31.0 | 28.3 | 19.8 | 43.9 |
| Inpatient Utilization | Inpatient Discharges per 1,000 Enrollee Months: Age 65 and Older | 22 | 36.7 | 27.6 | 22.3 | 57.1 |
| Inpatient Utilization | Inpatient Discharges per 1,000 Enrollee Months: Total (All Ages) | 30 | 35.8 | 26.9 | 16.0 | 42.8 |
| Inpatient Utilization | Inpatient Average Length of Stay: Ages 0 to 17 | 22 | 8.1 | 7.3 | 4.0 | 10.5 |
| Inpatient Utilization | Inpatient Average Length of Stay: Ages 18 to 64 | 28 | 8.1 | 6.1 | 5.2 | 8.1 |
| Inpatient Utilization | Inpatient Average Length of Stay: Age 65 and Older | 21 | 7.8 | 7.2 | 5.4 | 9.0 |
| Inpatient Utilization | Inpatient Average Length of Stay: Total (All Ages) | 29 | 7.2 | 6.3 | 5.2 | 8.7 |

Source: Mathematica analysis of the QMR system reports for the FFY 2022 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 2022 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 2022. 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