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Recommendations for Improving the Medicaid Health Home Core Set of Health Care Quality Measures

Summary of a Workgroup Review of the 2023 Health Home Core Set

Final Report

November 2022

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Mathematica also acknowledges the contributions of the Health Home Core Set Annual Review Workgroup members. Each member brought an invaluable perspective that informed the recommendations for the 2023 Health Home Core Set. In particular, we thank the Workgroup co-chairs, Fran Jensen and Kim Elliot, for their insightful leadership. We also appreciate the participation of the federal liaisons, who provided cross-agency insight during the meetings.

In addition, we express our gratitude to the measure steward for providing information on the measure under consideration and thank them for responding to questions from the Workgroup during the meeting.

Mathematica also appreciates the comments provided by members of the public during the Workgroup meetings. The diversity of perspectives enriched the discussion about strengthening the Health Home Core Set.

Finally, we thank the staff in the Disabled and Elderly Health Programs Group and the Division of Quality and Health Outcomes at the Center for Medicaid and CHIP Services for their input and guidance.

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Acronyms

CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
ED	Emergency department
FFY	Federal fiscal year
FUA-HH	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUM-HH	Follow-Up After Emergency Department Visit for Mental Illness
HHS	Department of Health and Human Services
HIV	Human immunodeficiency virus
MCO	Managed care organization
NCI	National Core Indicators
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PQI92-HH	Prevention Quality Indicator (PQI) #92: Chronic Conditions Composite
Q&A	Question and answer
SED	Serious emotional disturbance
SMI	Serious mental illness
SPA	State plan amendment
SUD	Substance use disorder
TA/AS	Technical Assistance and Analytic Support
T-MSIS	Transformed Medicaid Statistical Information System

Executive Summary

The Medicaid health home program, authorized under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), permits states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with complex needs. Health homes integrate physical and behavioral health (both mental health and substance use) and long-term services and supports for high-need, high-cost Medicaid populations. As of March 2022, 20 states[1] have 34 approved health home programs, with some states submitting multiple state plan amendments (SPAs) to target different populations.[2,3,4]

To help ensure that health home enrollees receive high quality and equitable care, the Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care health home enrollees receive and to drive improvement in care delivery and health outcomes. The Health Home Core Set of health care quality measures is a key tool in this effort.

The purpose of the Health Home Core Set is to estimate the overall quality of care for Medicaid health home enrollees based on a uniform set of health care quality measures. CMS and states use the Health Home Core Set measures to monitor access to and quality of health care for health home enrollees, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives.

To ensure the Health Home Core Set continues to reflect and be responsive to the needs of the health home population, the Health Home Core Set Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Health Home Core Set. The annual review includes input from a variety of groups, including but not limited to states, managed care plans, health care providers, and quality experts.

CMS contracted with Mathematica to convene the 2023 Medicaid Health Home Core Set Annual Review Workgroup. The Workgroup included 14 members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and improvement (see inside front cover for a list of members).

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[1] The term "states" includes the 50 states and the District of Columbia.

[2] A list of all approved health home programs as of March 2022 is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-spa-overview.pdf.

[3] A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid program. When a state is planning to change its program policies or operational approach, the state submits a SPA to the Centers for Medicare & Medicaid Services for review and approval. More information on health home programs is available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

[4] Health Home Core Set measures are reported at the program (SPA) level.

The Workgroup was charged with assessing the 2022 Health Home Core Set to strengthen and improve the 2023 Health Home Core Set. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Health Home Core Set based on several criteria that support the use of the Health Home Core Set measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid health home enrollees. See Exhibit ES.1 for the criteria that Workgroup members considered during the 2023 Health Home Core Set Annual Review.

Exhibit ES.1. Criteria Considered for Removal of Existing Measures and Addition of New Measures

Criteria Considered for Removal of Existing Measures	
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the program level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
3.	The specifications and data source do not allow for consistent calculations across health home programs (e.g., there is variation in coding or data completeness across health home programs).
4.	The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority	
1.	Taken together with other Health Home Core Set measures, the measure does not contribute to estimating the quality of health care in Medicaid health home programs or does not allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid beneficiaries.
2.	The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
3.	The measure cannot be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure is topped out or improvement is outside the direct influence of Medicaid health home programs/providers).
Other Considerations	
1.	The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid population sizes and demographics.
2.	The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3.	All health home programs may not be able to produce the measure by the federal fiscal year (FFY) 2024 Core Set reporting cycle or may not be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Exhibit ES.1 *(continued)*

Criteria Considered for Addition of New Measures	
Minimum Technical Feasibility Requirements (all requirements must be met)	
1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level (e.g., numerator, denominator, and value sets).
2.	The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP agencies.
3.	An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
4.	The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Health Home Core Set.
Actionability and Strategic Priority	
1.	Taken together with other Health Home Core Set measures, the measure can be used to estimate the quality of health care in Medicaid health homes and to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid beneficiaries.
2.	The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
3.	The measure can be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid health home programs/providers).
Other Considerations	
1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid population sizes and demographics.
2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3.	All health home programs should be able to produce the measure by the FFY 2024 Core Set reporting cycle and be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually on July 19, 2022, to discuss one measure suggested for addition to the 2023 Health Home Core Set, *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions*. The Workgroup did not consider any measures for removal. For a measure to be recommended for removal from or addition to the Health Home Core Set, at least two-thirds of the Workgroup members eligible to vote on a measure must vote in favor of removal or addition. The Workgroup discussed the measure and did not recommend it for addition to the 2023 Health Home Core Set. The Workgroup, therefore, did not recommend any changes to the 2023 Health Home Core Set.

In addition to discussing the measure suggested for addition, the Workgroup discussed two special topics: (1) opportunities for improving data availability and actionability and (2) leveraging measure stratification to advance health equity through the Health Home Core Set. Workgroup members emphasized the importance of health home programs having real-time

access to actionable data that can be used to drive improvement in care. Workgroup members encouraged opportunities to leverage data to realize efficiencies in reporting and reduce state reporting burden. The Workgroup also discussed the need to develop, refine, and test measures that can be used in the Medicaid health home program and emphasized the need for technical assistance to support states and health home care managers in using the data to improve health care outcomes. Workgroup members acknowledged the challenges of stratifying the Health Home Core Set measures by race, ethnicity, geography, and other sociodemographic characteristics but expressed broad support for using the Health Home Core Set to understand health disparities, screen for the social determinants of health, and advance health equity.

This report summarizes the 2023 Health Home Core Set Annual Review Workgroup's review process, discussion, and recommendations. The draft report was made available for public comment from September 30, 2022 through October 28, 2022 and no public comments were received. CMS will review the final report to inform decisions about whether and how to modify the 2023 Health Home Core Set. Additionally, CMS will obtain input from federal agencies to ensure that the Health Home Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government. CMCS will release the 2023 Health Home Core Set by December 31, 2022.

Introduction

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with complex needs.[5] Health homes integrate physical and behavioral health (both mental health and substance use) and long-term services and supports for high-need, high-cost Medicaid populations. States interested in implementing a health home program must submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS).[6] States are able to target Medicaid health home enrollment based on condition and geography but cannot limit enrollment by age, delivery system, or dual eligibility status. Each health home program requires a separate SPA.[7] As of March 2022, 20 states[8] have 34 approved health home programs, with some states submitting multiple SPAs to target different populations.[9,10]

To qualify for Medicaid health home services, beneficiaries must meet one of the following criteria: have a diagnosis of two chronic conditions, have a diagnosis of one chronic condition and be at risk for a second, or have a diagnosis of a serious mental illness. Section 1945(h)(2) of the Social Security Act defines “chronic condition” to include mental health conditions, substance use disorder (SUD), asthma, diabetes, heart disease, and overweight (body mass index over 25). Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.[11]

Additionally, Medicaid health home programs must provide the following core services to enrollees:

- Comprehensive care management
- Care coordination

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[5] Beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions as defined in section 1945A(i) of the Social Security Act. More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf.

[6] More information on Medicaid health home programs is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html.

[7] A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid program. When a state is planning to change its program policies or operational approach, the state submits a SPA to CMS for review and approval. More information on health home programs is available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

[8] The term “states” includes the 50 states and the District of Columbia.

[9] A list of all approved health home programs as of March 2022 is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-spa-overview.pdf.

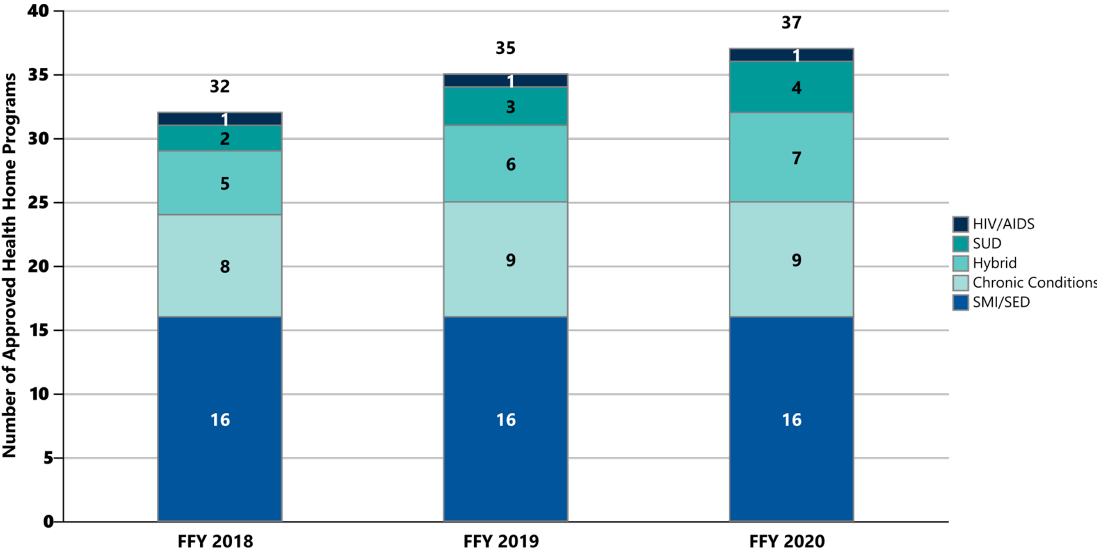
[10] Health Home Core Set measures are reported at the program (SPA) level.

[11] More information is available at https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

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

Exhibit 1 shows the distribution of approved health home programs by target population from federal fiscal year (FFY) 2018 to FFY 2020. The number of approved health home programs has increased over time. In FFY 2020, 16 health home programs served people with serious mental illness, and another 9 programs served people with chronic conditions. Seven hybrid health home programs had two or more focus areas.

Exhibit 1. Number of Health Home Programs by Target Population, FFY 2018−FFY 2020



Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, April 2021. Available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set-chart-pack-ffy-2020.pdf.

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

FFY = federal fiscal year; SMI/SED = serious mental illness/serious emotional disturbance; SUD = substance use disorder.

To help ensure that health home enrollees receive high-quality and equitable care, CMS and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that health home enrollees receive and to drive improvement in care delivery and health outcomes. The Health Home Core Set of health care quality measures is a key tool in this effort.

The purpose of the Health Home Core Set is to estimate the overall quality of care for Medicaid health home enrollees based on a uniform set of health care quality measures. CMS and states use the Health Home Core Set measures to monitor access to and quality of health care for health home enrollees, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives to drive improvement in the quality of care.

To ensure the Health Home Core Set continues to reflect and respond to the needs of the health home population, the Health Home Core Set Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Health Home Core Set. The annual review includes input from a variety of groups, including but not limited to states, managed care plans, health care providers, and quality experts. The Health Home Core Set has undergone these annual reviews since 2021.

CMS contracted with Mathematica to convene the 2023 Medicaid Health Home Core Set Annual Review Workgroup.[12,13] The Workgroup included 14 members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and improvement (see inside front cover of this report for a list of members).

The Workgroup was charged with assessing the 2022 Health Home Core Set to strengthen and improve the 2023 Health Home Core Set. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Health Home Core Set based on several criteria that support the use of the Health Home Core Set measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid health home enrollees.

This report provides an overview of the Health Home Core Set, describes the 2023 Health Home Core Set Annual Review process and summarizes the Workgroup's recommendations for improving the Health Home Core Set. A draft of this report was made available for public comment from September 30, 2022 through October 28, 2022 and no public comments were received.

Overview of the Health Home Core Set

CMS established the Health Home Core Set of Quality Measures in January 2013 for the purpose of ongoing monitoring and evaluation across all health home programs. States reported Health Home Core Set measures for the first time for FFY 2013. States recently completed Health Home Core Set reporting for FFY 2020, which generally covers services delivered in calendar year 2019. As a condition of receiving payment for Section 1945 health home services, Medicaid health home providers are required to report quality measures to the state, and states are expected

[12] More information about the annual review of the Health Home Core Set is available at https://www.mathematica.org/features/hhcoresetreview.

[13] Mathematica also supported CMS by convening the Child and Adult Core Set Annual Review Workgroup to review and strengthen the 2023 Child and Adult Core Sets. More information about the annual review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview.

to report these measures to CMS (42 U.S.C. Section 1945(g)). States are expected to report all Health Home Core Set measures, regardless of the health home program focus area, and states are expected to report the measures separately for each of their health home programs.

The 2022 Health Home Core Set

The 2022 Health Home Core Set includes 13 measures; 10 are quality measures and 3 are utilization measures. Appendix A includes tables listing the 2022 Health Home Core Set measures and the history of measures included in the Health Home Core Set. Of the 13 measures in the 2022 Health Home Core Set, about three-fifths were part of the initial Health Home Core Set established in 2013. All the measures can be calculated using an administrative data collection methodology.

CMS publicly reports data for Health Home Core Set measures that at least 15 health home programs reported and that met CMS standards for data quality.[14] Highlights for FFY 2020 Health Home Core Set reporting,[15] the most recent year for which data are publicly available, include the following:

- Of the 37 health home programs expected to report Health Home Core Set measures for FFY 2020, 34 programs reported at least one measure. The other three programs did not submit data in time to be included in publicly reported data.
- States reported a median of 9 of the 12 Health Home Core Set measures for FFY 2020.[16]
- Between FFY 2018 and FFY 2020, six measures were reported by at least two-thirds of the 26 health home programs that were expected to report in all three reporting years.
- Reporting remained consistent or increased for 24 of the 26 health home programs that reported for all three years from FFY 2018 to FFY 2020.
- Reporting increased for all nine measures included in both the FFY 2018 and FFY 2020 Health Home Core Sets.

Exhibit 2 summarizes the number of health home programs reporting the Health Home Core Set measures for FFY 2020. The most commonly reported measures for FFY 2020 were the *Ambulatory Care: Emergency Department (ED) Visits* measure, the *Follow-Up After*

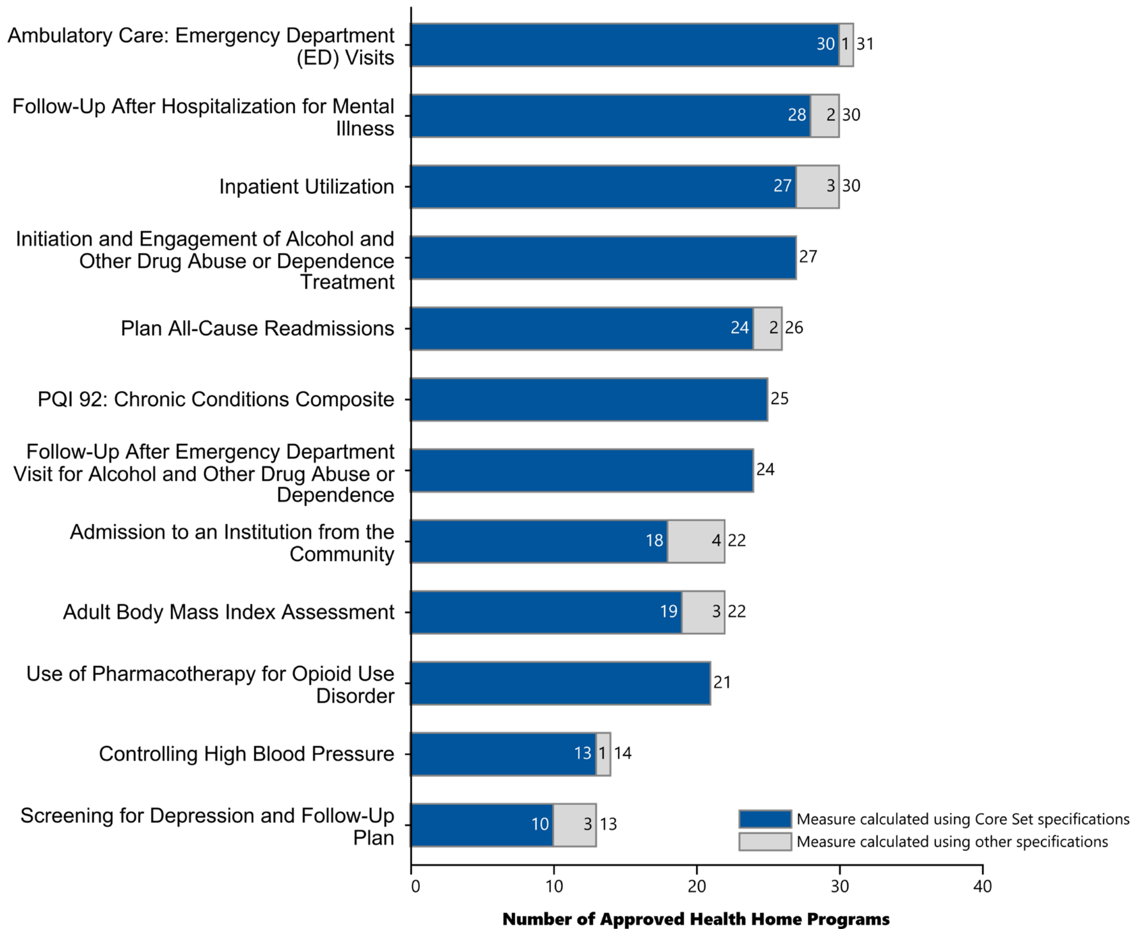
[14] More information about performance analysis and trending of Health Home Core Set measures is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/health-home-core-set-methods-brief-nov-2021.pdf.

[15] More information on health home quality reporting 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.

[16] As shown in Appendix A, Exhibit A.2, the 2020 Health Home Core Set included 12 measures and the 2022 Health Home Core Set included 13 measures. Two measures were added to the 2022 Health Home Core Set (*Colorectal Cancer Screening* and *Follow-up After Emergency Department Visit for Mental Illness* and one measure was retired from the 2021 Health Home Core Set (*Adult Body Mass Index Assessment*).

Hospitalization for Mental Illness measure, and the *Inpatient Utilization* measure. The least frequently reported measures for FFY 2020 were the *Screening for Depression and Follow-Up Plan* measure and the *Controlling High Blood Pressure* measure.

Exhibit 2. Number of Health Home Programs Reporting the FFY 2020 Health Home Core Set Measures



Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, April 2021. Available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set-chart-pack-ffy-2020.pdf.

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

FFY = federal fiscal year; PQI = Prevention Quality Indicator.

State Challenges with Reporting the Health Home Core Set Measures

Understanding state challenges with reporting the Health Home Core Set measures is important in assessing the feasibility of calculating existing measures as well as those suggested for

addition to the Health Home Core Set. The most common reason states cited for not reporting a Health Home Core Set measure for FFY 2020 was that they did not collect the data or lacked the ability to link data sources to calculate the measure. Another common barrier included staff and budgetary constraints. Finally, small health home populations and continuous enrollment requirements limited the number of health home enrollees who were eligible for some of the measures.

Use of the Health Home Core Set for Quality Measurement and Improvement

CMS and states use the Health Home Core Set to monitor and improve the quality of care provided to Medicaid beneficiaries enrolled in health homes and to measure progress over time. CMS publicly reports information on state performance on the Health Home Core Set annually through chart packs and other resources.[17]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMS supports states and their partners in collecting, reporting, and using the Health Home Core Set measures to drive improvement in Medicaid health home programs, while striving to achieve several goals for reporting. These goals include maintaining or increasing the number of health home programs that report the Health Home Core Set measures, maintaining or increasing the number of measures that states report for each of their health home programs, and improving the quality and completeness of the data reported.[18] CMS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Health Home Core Set reporting for states, and improve the transparency and comparability of the data reported across health home programs. The TA/AS Program offers states various opportunities to address technical issues related to collecting and reporting the Health Home Core Set measures, including a technical assistance mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars.

Description of the 2023 Health Home Core Set Annual Review Process

This section describes the 2023 Health Home Core Set Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2023 Health Home Core Set Annual Review included 14 voting members affiliated with state Medicaid agencies and other organizations from across the country.

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[17] Chart packs, measure-specific tables, facts sheets, and other Health Home Core Set annual reporting resources 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.

[18] More information about the CMS TA/AS Program is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/tafactsheet.pdf.

See the inside front cover of this report for a list of the Workgroup members. The Workgroup was initially selected through a Call for Nominations issued in February 2021 in conjunction with the 2022 Health Home Core Set Annual Review. The Workgroup roster has changed slightly each year because of resignations due to career transitions. New Workgroup members have been identified, as needed, through outreach to nominating organizations.

The 2023 Health Home Core Set Annual Review Workgroup members offered expertise in health home quality measurement and improvement as well as subject matter expertise related to the needs of Medicaid health home enrollees, such as behavioral health and long-term services and supports. Although Workgroup members have individual affiliations, they agreed to participate as stewards of the Medicaid health home program as a whole and not from their individual points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for the program.

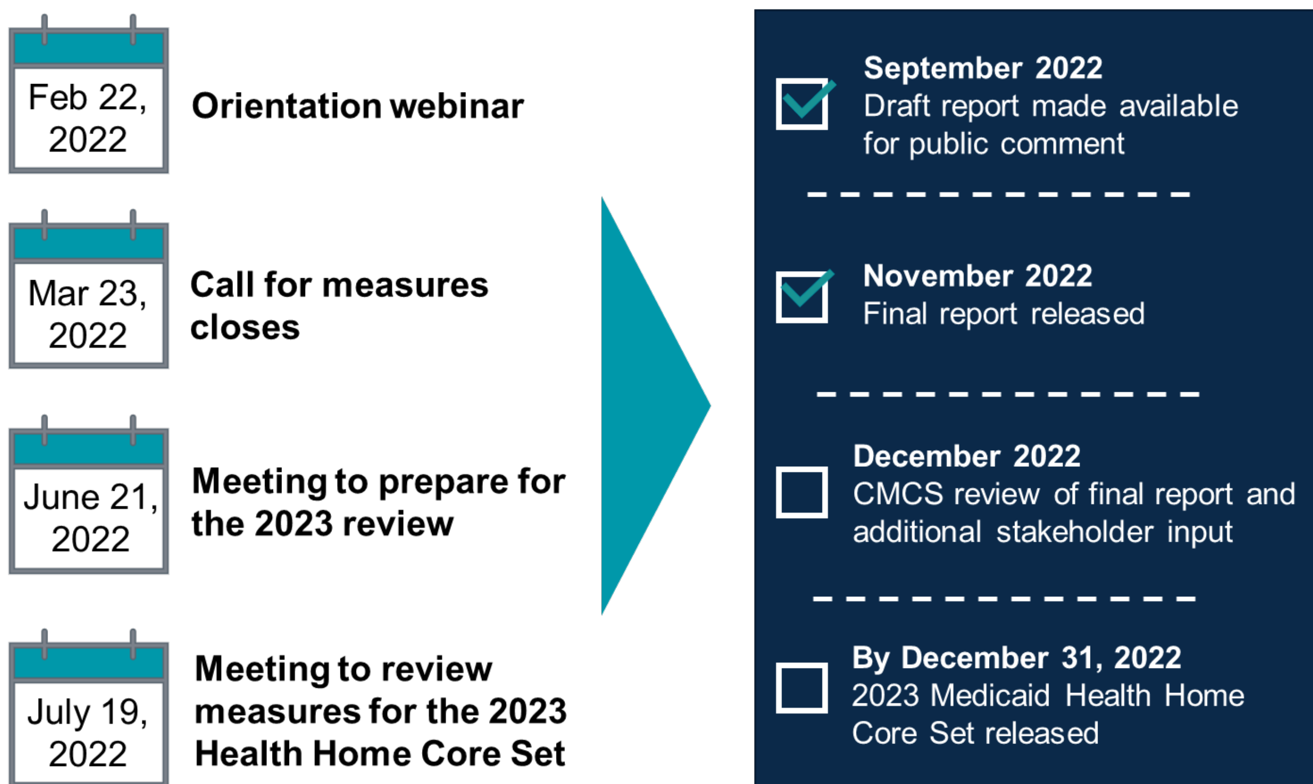
Workgroup members were required to submit a Disclosure of Interest form to report any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict of interest related to the current Health Home Core Set measures or other measures reviewed during the Workgroup process. Workgroup members who were deemed to have an interest in a measure recommended for consideration were required to recuse themselves from voting on that measure.

The Workgroup also included nonvoting federal liaisons, who represented seven agencies (see inside front cover). The inclusion of federal liaisons reflects CMS's commitment to promoting quality measurement alignment and working in partnership with other federal agencies to collect, report, and use the Health Home Core Set measures to drive improvement in care delivery and health outcomes for Medicaid health home enrollees.

Workgroup Timeline and Meetings

Mathematica held webinars in February 2022 and June 2022 to orient the Workgroup members to the review process and prepare them for the 2023 Health Home Core Set Annual Review voting meeting, which took place virtually in July 2022 (Exhibit 3). All meetings were open to the public, and members of the public could comment during each meeting.

Exhibit 3. Timeline for the 2023 Health Home Core Set Annual Review Workgroup



Orientation Webinar

During the orientation webinar on February 22, 2022, Mathematica outlined the Workgroup charge, introduced the Workgroup members, and provided background on the Health Home Core Set.

> **Workgroup Charge**
>
> The Medicaid Health Home Core Set Workgroup for the 2023 Annual Review is charged with assessing the 2022 Medicaid Health Home Core Set and recommending measures for addition or removal in order to strengthen and improve the Medicaid Health Home Core Set.
>
> The Workgroup should focus on recommending measures that are actionable, aligned, and appropriate for program-level reporting, to ensure the measures can meaningfully drive improvement in quality of care and outcomes for Medicaid health home program enrollees.

After providing an overview of the process for the 2023 Health Home Core Set Annual Review, Mathematica reviewed the outcomes of the 2022 Annual Review and discussed gaps the Workgroup identified during the 2022 Annual Review. Mathematica described the additional input that CMS will obtain during the 2023 Annual Review process, including input from federal partners and internal partners within CMS.

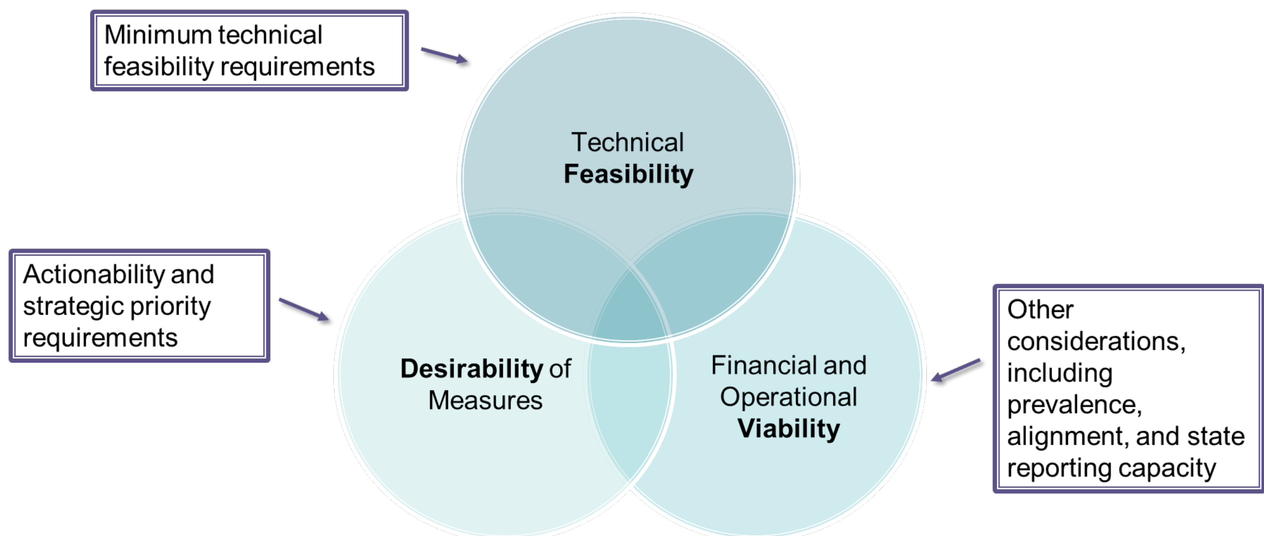
Mathematica also explained the Call for Measures process, through which Workgroup members suggest measures for addition to or removal from the Health Home Core Set. Mathematica asked

Workgroup members to balance three interdependent components when considering measures for addition or removal: (1) the technical feasibility of measures, (2) the desirability of measures, and (3) the financial and operational viability for states.

To operationalize these three components, Mathematica identified a comprehensive set of criteria used to assess measures during all phases of the Workgroup process. As Exhibit 4 shows, the Workgroup was charged with focusing on measures that met the following criteria:

- **Minimum technical feasibility requirements:** Availability of detailed technical specifications that enable production of the measure at the program level, evidence of field testing or use in a state Medicaid or CHIP program, availability of a data source with all the necessary data elements to produce consistent calculations across health home programs, and technical specifications provided at no charge for state use.
- **Actionability and strategic priority requirements:** Contributes to estimating the overall quality in Medicaid health home programs together with other Health Home Core Set measures; allows for comparative analyses of racial, ethnic, and socioeconomic disparities; provides useful and actionable results to drive improvement in care delivery and health outcomes; and addresses a strategic performance measurement priority.
- **Other considerations:** Sufficient prevalence of the condition or outcome being measured to produce meaningful and reliable results across health home programs, alignment with measures used in other CMS programs (including the Child and Adult Core Sets), and capacity for all health home programs to report the measure by FFY 2024.

Exhibit 4. Framework for Assessing Measures for the 2023 Health Home Core Set



Call for Measures

Following the orientation meeting, the Workgroup members and federal liaisons were invited to suggest measures for addition to or removal from the Health Home Core Set to strengthen and improve the Health Home Core Set for 2023. Workgroup members used an online form to submit suggestions for addition or removal, and were asked to provide the following information about the measure(s):

- The rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for addition or removal
- Whether the data source allows for stratification of the measure by racial, ethnic, and sociodemographic characteristics
- Information that justifies discussing the measure again, if the Workgroup had previously reviewed the measure
- Whether removal of the measure would leave a gap in the Health Home Core Set
- Whether another measure was proposed to replace the measure suggested for removal
- Whether a measure suggested for addition was intended to replace a current Health Home Core Set measure
- Potential barriers states could face in calculating the measures suggested for removal or addition by the FFY 2024 reporting cycle

The Call for Measures was open from February 23 to March 23, 2022. One measure was suggested for addition to the 2023 Health Home Core Set and no measures were suggested for removal.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on June 21, 2022. To prepare Workgroup members for the discussion at the 2023 Annual Review meeting, Mathematica provided information about the one measure to consider for addition. Mathematica provided guidance to the Workgroup about how to prepare for the measure discussion, including the criteria that Workgroup members should consider for recommending a measure for addition to the Health Home Core Set and the resources available to aid in their review. These resources included a detailed measure information sheet for the suggested measure, a worksheet to record questions and notes for the measure, links to chart packs and measure-specific tables, and the resource manuals and technical specifications for the Child, Adult, and Health Home Core Sets. Workgroup members were asked to review all materials related to the measure; complete the measure worksheet; and

attend the Annual Review meeting prepared with notes, questions, and preliminary votes on the measure proposed for addition.

2023 Health Home Core Set Annual Review Meeting

The 2023 Health Home Core Set Annual Review voting meeting took place virtually on July 19, 2022. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

As described later in this report, Workgroup members discussed one measure suggested for addition. Mathematica noted the key technical specifications and summarized the rationale that the Workgroup member provided for suggesting the measure for addition. Mathematica then facilitated a discussion of the measure. Mathematica sought comments and questions from Workgroup members about the measure and asked the measure steward to clarify measure specifications when needed. After this discussion, members of the public could comment on the measure.

Voting took place after the Workgroup discussion and opportunity for public comment. Mathematica facilitated the voting on the measure suggested for addition. Workgroup members voted electronically through a secure web-based polling application during the specified voting period. Workgroup members who experienced technical difficulties with the voting tool could submit votes through the webinar question and answer (Q&A) feature (which was visible only to the Mathematica team). Workgroup members could select either "Yes, I recommend adding this measure to the Health Home Core Set" or "No, I do not recommend adding this measure to the Health Home Core Set."

If two-thirds of the eligible Workgroup members voted yes, the measure would be recommended for addition. The two-thirds voting threshold was adjusted according to the number of eligible Workgroup members present for the vote. Mathematica presented the voting results immediately after the vote and announced whether the results met the two-thirds threshold for the measure to be recommended for addition to the Health Home Core Set.

Following voting, Workgroup members had an opportunity to discuss gaps in the Health Home Core Set. A summary of the discussion about gaps in the Health Home Core Set appears later in this report.

The Workgroup also discussed two special topics during the Annual Review meeting: (1) opportunities for improving data availability and actionability and (2) leveraging measure stratification to advance health equity through the Health Home Core Set. A public comment period took place after the Workgroup discussion. A summary of the discussion appears later in this report.

Workgroup Recommendations for Improving the 2023 Health Home Core Set

Criteria Considered for Removal of Existing Measures and Addition of New Measures

To focus the Call for Measures for the 2023 Annual Review on measures that would be a good fit for the Health Home Core Set, Mathematica specified detailed criteria for the Workgroup to consider when assessing measures for removal from or addition to the Health Home Core Set. These criteria are classified under three areas: (1) technical feasibility, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

To be considered by the Workgroup, all measures suggested for addition must meet minimum technical feasibility criteria. Before the Annual Review meeting, Mathematica conducted a preliminary assessment of the one measure suggested for addition to ensure it adhered to the minimum technical feasibility criteria. In addition, Mathematica mentioned the following contextual factors to inform the Workgroup discussion:

- The Workgroup should consider alignment with current measures in CMS's Medicaid and CHIP Child and Adult Core Sets of health care quality measures (Child and Adult Core Sets) to achieve "multi-level alignment."
- The Workgroup should consider each measure on its own merits according to the criteria. The Health Home Core Set does not have a minimum or maximum number of measures.
- The Workgroup should review, discuss, and vote on the measure as it is currently specified by the measure steward.
- The Workgroup should consider the feasibility for all health home programs to report the measure by FFY 2024.

Exhibit 5. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2023 Health Home Core Set

Criteria Considered for Removal of Existing Measures	
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the program level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
3.	The specifications and data source do not allow for consistent calculations across health home programs (e.g., there is variation in coding or data completeness across health home programs).
4.	The measure is being retired by the measure steward and will no longer be updated or maintained.

Exhibit 5 (*continued*)

Actionability and Strategic Priority
1. Taken together with other Health Home Core Set measures, the measure does not contribute to estimating the quality of health care in Medicaid health home programs or does not allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid beneficiaries.
2. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
3. The measure cannot be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure is topped out or improvement is outside the direct influence of Medicaid health home programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All health home programs may not be able to produce the measure by the federal fiscal year (FFY) 2024 Core Set reporting cycle or may not be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).
Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP agencies.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Health Home Core Set.
Actionability and Strategic Priority
1. Taken together with other Health Home Core Set measures, the measure can be used to estimate the quality of health care in Medicaid health homes and to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid beneficiaries.
2. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
3. The measure can be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid health home programs/providers).

Exhibit 5 (*continued*)

Other Considerations	
1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid population sizes and demographics.
2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3.	All health home programs should be able to produce the measure by the FFY 2024 Core Set reporting cycle and be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Summary of Workgroup Recommendations

The Workgroup discussed one measure suggested for addition to the 2023 Health Home Core Set, *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions* (Exhibit 6). The Workgroup did not recommend adding this measure. The Workgroup, therefore, did not recommend any changes to the 2023 Health Home Core Set.

Mathematica noted that the Workgroup's decision to not make any changes to the 2023 Health Home Core Set may be an opportunity for creating stability in the Health Home Core Set, allowing states and health home programs to focus on reporting the current measures, while considering future opportunities to address gaps in the Health Home Core Set.

Exhibit 6. Measure Considered and Not Recommended for Addition to the 2023 Health Home Core Set

Measure Name	Measure Steward	NQF #
Measure Suggested but not Recommended for Addition		
Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions	NCQA	Not Endorsed

NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

Discussion of Measure Considered and Not Recommended for Addition

This section summarizes the discussion related to the measure considered for addition and the rationale for the Workgroup's decision not to recommend adding the measure to the Health Home Core Set. The Measure Information Sheet is available on the Mathematica Health Home Core Set Review website.[19] Exhibit 7 (at the end of this section) summarizes the Workgroup discussion about the measure.

[19] The Measure Information Sheet for the measure suggested for addition is available at https://www.mathematica.org/-/media/internet/features/2022/health-home-core-set/2023-health-home-core-set-review_measure-information-sheet.pdf.

Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions

The *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions* measure assesses the percentage of ED visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit. The measure is currently specified for use in the Medicare program and is part of the Medicare Advantage Quality Improvement Program. The Workgroup member who suggested it for addition noted that two states have considered using it in their Medicaid quality strategies. They noted that the measure contributes to assessing the overall quality of health home programs, as many programs enroll people with multiple chronic conditions. They added that health home enrollees with multiple chronic conditions are at risk of ED visits and that health home care managers are uniquely positioned to follow up after an ED visit to ensure the person's needs are being met.

The Workgroup discussion focused on the measure's technical specifications as well as concerns about the measure being specified only for the Medicare program. One Workgroup member questioned whether the measure meets the minimum technical feasibility requirements to be considered for addition to the Health Home Core Set, which specify that the measure must have been tested in a state Medicaid and/or CHIP program or be in use by one or more state Medicaid and/or CHIP agencies. Mathematica responded that it included the measure for the Workgroup's consideration because it may apply to the health home population and states had considered it for their Medicaid quality strategies. Mathematica also prompted the Workgroup to consider whether the measure might be actionable and a strategic priority for health home programs, even if it might not be ready for inclusion in the 2023 Health Home Core Set.

Several Workgroup members expressed concern about the lack of testing and use of the measure at the state level. One Workgroup member said that testing provides an opportunity to understand where states may be having challenges with the measure. A Workgroup member asked whether any Medicare Advantage organizations had provided feedback about their experiences collecting and reporting the measure or their thoughts about the measure's usefulness. Another Workgroup member shared that the states they have worked with have expressed interest in the measure, but that it has been challenging for them to implement because it is specified for Medicare. A Workgroup member wondered if there were technical reasons that the measure steward, the National Committee for Quality Assurance (NCQA), did not specify the measure for Medicaid.

Some Workgroup members also questioned their understanding of the measure's technical specifications, uncertain about how and why certain conditions were grouped in the measure denominator. For example, a Workgroup member was unclear about why chronic obstructive pulmonary disease and asthma are grouped together when they are different conditions. One Workgroup member clarified that the conditions are grouped because their codes fall under the same value set, and that the measure specifications consider them to be part of the same category

of chronic conditions. Another Workgroup member explained that chronic conditions must be found in at least two different value sets for the ED visit to be eligible for inclusion in the measure denominator. A Workgroup member speculated that this grouping might be based on existing clinical groupers that cluster diagnoses based on predictors of morbidity, rather than the presence of specific diseases. A Workgroup member also questioned whether the suggested measure appropriately captures the chronic conditions that are most prevalent among health home enrollees, noting that HIV/AIDS and diabetes are not included in the denominator but are among the most common chronic conditions in the health home programs they oversee.

The Workgroup also discussed the potential that adding the *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions* measure might duplicate existing measures in the Health Home Core Set. One Workgroup member questioned the value of adding the measure because the *Prevention Quality Indicator (PQI) #92: Chronic Conditions Composite* (PQI92-HH) measure currently in the Health Home Core Set also covers chronic conditions.[20] Another Workgroup member voiced concern about adding a measure with "considerable overlap" with two other Health Home Core Set measures, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-HH) and *Follow-Up After Emergency Department Visit for Mental Illness* (FUM-HH). The Workgroup member said they would be more open to adding the measure if the Workgroup considered removing FUA-HH and FUM-HH, desiring a more parsimonious measure set.

Despite these concerns, some Workgroup members acknowledged the importance of the measure. One Workgroup member noted that the chronic conditions listed in the measure denominator affect Medicaid enrollees and that including the measure in the Health Home Core Set would be reasonable. Another Workgroup member agreed, commenting that supporting enrollees with chronic conditions is an important part of the services health home programs provide. They added that the measure aligns with a strategic priority of the health home program, specifically related to containing the total cost of care.

[20] The PQI92-HH 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 disorder, asthma, hypertension, or heart failure without a cardiac procedure. The *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions* includes members who had two or more of the following chronic condition diagnoses: chronic obstructive pulmonary disorder and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, and stroke and transient ischemic attack.

Exhibit 7. Summary of the Discussion of the Measure Not Recommended for Addition to the 2023 Health Home Core Set

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measure discussed and not recommended for addition to the 2023 Health Home Core Set			
Follow-Up After Emergency Department (ED) Visit for People With Multiple Chronic Conditions Measure steward: NCQA	Not endorsed	The percentage of ED visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. Data collection method: Administrative	• Suggested for addition because the measure contributes to assessing the overall quality of health home programs and could support improvement of care for health home enrollees with multiple chronic conditions • Concern that the measure has not been tested in a state Medicaid and/or CHIP program and is not in use by one or more state Medicaid and CHIP agencies • Concern about the measure being specified only for Medicare • Questions about the grouping of chronic conditions in the measure denominator • Discussion about potential for this measure to duplicate the PQI92-HH, FUA-HH, and FUM-HH measures

CHIP = Children's Health Insurance Program; ED = emergency department; FUA-HH = Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence; FUM-HH = Follow-Up After Emergency Department Visit for Mental Illness; NCQA = National Committee for Quality Assurance; PQI92-HH = Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite.

Discussion of Gaps in the Health Home Core Set

During the 2023 Health Home Core Set Annual Review, the Workgroup identified and discussed gaps in the Health Home Core Set. Mathematica asked the Workgroup to identify what types of measures or measure concepts are missing, whether any existing measures could fill the gaps, or whether new measures would need to be developed. Exhibit 8 synthesizes the gaps mentioned during Workgroup discussion and the public comment period. The exhibit does not prioritize the suggested gaps or assess their feasibility or fit for the Health Home Core Set.

Workgroup members frequently identified gaps in the Health Home Core Set related to care coordination and screening for the social determinants of health. Additionally, Workgroup members noted gaps in measures of preventive and primary care in the context of ensuring that this aspect of a health home enrollee's care does not get overlooked among their more complex conditions. These measure gaps align with a focus on the core services that Medicaid health home programs must provide to enrollees, including care management, care coordination, and health promotion. [21] However, Workgroup members acknowledged challenges related to sharing

[21] Medicaid health home programs must provide the following core services to enrollees: comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings (continued)

information with health home care managers if the information is sensitive or protected, such as about SUD treatment or HIV viral load suppression, which could affect the actionability of these measures for health home care managers and care coordinators.

Throughout the voting meeting, Workgroup members consistently underscored a desire to use the Health Home Core Set to understand health disparities and advance health equity. They expressed an interest in stratifying the measures by demographic characteristics, such as race and ethnicity, and reflected on gaps in measuring the social determinants of health. A summary of the Workgroup discussion on this topic appears later in this report.

Workgroup members identified several gaps related to capturing the person's experience navigating the health care system through the Health Home Core Set. Workgroup members discussed opportunities to address multiple gap areas in the Health Home Core Set through the addition of a patient experience of care survey to the measure set, which could include questions about gaps related to health disparities, access to care, and care coordination.

The Workgroup's reflections about gaps in the Health Home Core Set provide a strong starting point for future discussions about updates, as well as longer-term planning for the Health Home Core Set.

Exhibit 8. Synthesis of Workgroup Discussions About Potential Gaps in the Health Home Core Set

Potential Gaps in the Health Home Core Set
Measure-specific Gaps
• Assess social determinants and drivers of health, including housing status and food insecurity, as well as referral and follow-up • Hepatitis C screening • Primary and preventive care, including adults' access to care, annual well visits, primary care practitioner visits, and weight management • Health promotion • HIV care • Maternal and child health, including prenatal and postpartum care • Patient experience of care and satisfaction with care
Measure Concepts Related to Care Delivery
• Integration and coordination of behavioral, mental, and physical health services • Care coordination, including whether health homes are successfully coordinating care and whether health home enrollees know how to reach their teams for care coordination • Beneficiaries' ease of using the health care system, ability to move throughout the system, and ability to get timely, needed care

including appropriate follow-up, individual and family support, referral to community and social support services, and the use of health information technology to link services as feasible and appropriate. More information is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

Exhibit 8 (*continued*)

Potential Gaps in the Health Home Core Set
Cross-cutting Methodological Considerations
• Measure disparities among sub-populations of health home enrollees • Stratify measures by race, ethnicity, language, geography, and other socioeconomic and sociodemographic characteristics • Stratify measures for health home enrollees compared with non-health home enrolled Medicaid beneficiaries with similar chronic conditions as well as the overall Medicaid population • Use existing data sources to realize efficiencies in reporting and reduce state burden (for example, data from the Transformed Medicaid Statistical Information System, Child and Adult Core Sets) • Avoid measures that require chart review • Take into account challenges related to sharing information with providers to measure all the care health home enrollees receive • Consider reducing the number of measures in the Health Home Core Set focused on substance use disorder • Align measure titles and descriptions with current practice and inclusive language

Considerations for the Future of the Health Home Core Set

Mathematica solicited feedback from the Workgroup about considerations for the future of the Health Home Core Set. This feedback covered opportunities to (1) improve data availability and actionability and (2) advance health equity by stratifying measures.

Opportunities to Improve Data Availability and Actionability for Health Home Programs

The Workgroup highlighted four primary opportunities: (1) increasing access to real-time data to support quality improvement; (2) improving data sharing to yield more actionable data; (3) using alternative data sources to realize efficiencies in reporting and reduce state burden; and (4) refining and testing measures that could be used in the health home program.

Access to Real-Time Data

The Workgroup underscored the need to provide actionable data to health home providers to facilitate real-time monitoring and quality improvement. Workgroup members noted that, unlike other CMS Medicaid and CHIP quality measurement programs, the Medicaid health home program operates at the provider level, where real-time access to data that care managers can use to understand gaps in care is important for quality improvement. To help ensure that health home data are useful to providers, a few Workgroup members suggested asking providers and others doing on-the-ground work about the type of information they need to impact performance,

and ultimately improve care. Another Workgroup member suggested that states could use their health information exchanges to gather clinical data in real time rather than waiting for a claim to process.

Improved Data Sharing

Several Workgroup members noted substantial challenges sharing data related to sensitive or protected conditions, including SUD and HIV/AIDS, both of which might qualify a beneficiary to be enrolled in a Medicaid health home program. Workgroup members explained that managed care organizations (MCOs) cannot share data on sensitive conditions with health home care managers without beneficiary consent. Without access to these data, Workgroup members said that care managers may not be able to identify beneficiaries with care gaps and effectively address these gaps. For example, one Workgroup member who works for an MCO discussed the difficulty of sharing SUD data with health home care managers, given the sensitivity of the information. They questioned whether this data-sharing barrier could be mitigated by changing the flow of the data—having states rather than MCOs share the data with health home providers and care managers. Another Workgroup member mentioned similar challenges when discussing the possibility of adding an HIV measure to the Health Home Core Set, noting that the sensitivity of the information prevents their state from sharing member-level data with health home providers.

The Use of Alternative Data Sources

To reduce reporting burden and promote consistency across states, Mathematica shared that CMS is exploring the use of alternate data sources for Health Home Core Set reporting, such as Transformed Medicaid Statistical Information System (T-MSIS) data. Workgroup members discussed the advantages and disadvantages of using T-MSIS data for Health Home Core Set reporting, reflecting on Mathematica's observations that (1) health home enrollees are not consistently identified in T-MSIS and also that (2) health home enrollees are not attributed to a specific health home program in states with more than one approved health home program. One Workgroup member expressed apprehension about the actionability of T-MSIS data, particularly for the health home providers who are responsible for delivering the required health home services. Two Workgroup members noted that T-MSIS is retrospective, which is good for state reporting but impractical for real-time monitoring.

A Workgroup member representing a state Medicaid agency suggested that states could use "restriction exception" or exclusion codes to flag members in specific Medicaid health home programs to prevent duplication of services. The Workgroup member encouraged CMS to begin testing the calculation of existing or potentially new Health Home Core Set measures using T-MSIS and share the data back with states for review and feedback, similar to the approach used for Form CMS-416 and a subset of the Child and Adult Core Set measures. They noted that this approach could reduce the reporting and resource burden on states. Another Workgroup member representing an MCO indicated that some state health home programs denote Medicaid

beneficiaries who might be eligible for health home services, but not all beneficiaries actually receive those services from health home providers.

The Workgroup also supported opportunities to use stratification to address potential gaps in the Health Home Core Set without increasing the burden of state reporting. A few Workgroup members suggested stratifying measures reported for the Child and Adult Core Sets by the health home population, since reporting on the Child Core Set and behavioral health measures in the Adult Core Set will become mandatory for FFY 2024. One Workgroup member suggested that stratifying the measures in this way would enable providers to view performance among health home enrollees alongside people with similar chronic conditions not enrolled in health homes, as well as the broader Medicaid population. Another Workgroup member suggested that this stratification could identify disparities in outcomes, which would be preferable to adding a measure on screening for health-related social needs to the Health Home Core Set.

Refining and Testing New Measures

Some Workgroup members emphasized the need to test additional measures for Medicaid overall and specific to the Medicaid health home program. One Workgroup member noted that the Workgroup has more difficulty assessing measures not specified for the Medicaid program. This Workgroup member added that measure developers could help test and potentially enhance measures that are currently only specified for Medicare and commercially insured populations but that might also apply to the health home program.

Opportunities to Advance Health Equity Through the Health Home Core Set

Mathematica engaged the Workgroup in a conversation about opportunities to advance health equity through the Health Home Core Set. Mathematica opened the conversation noting that health equity is a priority for CMS and states and that stratifying the measures by sociodemographic characteristics would be one way to advance health equity through the Health Home Core Set. Mathematica noted that although states currently have the option to stratify the measures by race, ethnicity, geography, language, and disability, few states have done so. Mathematica asked the Workgroup to reflect on (1) their experiences stratifying Health Home Core Set measures to assess performance of health home programs, (2) barriers to stratifying Health Home Core Set measures by sociodemographic characteristics, and (3) what technical assistance states might need to help them calculate and report stratified Health Home Core Set measures.

During this conversation and throughout the voting meeting, several Workgroup members encouraged stratifying Health Home Core Set measures by sociodemographic characteristics including race, ethnicity, and geography to identify and address health disparities among health home enrollees. Workgroup members also emphasized that stratification could help health home care managers identify care gaps among different sub-populations of health home enrollees, such as people with intellectual and developmental disabilities.

Reflecting on the challenges of stratifying Health Home Core Set measures by sociodemographic characteristics, a Workgroup member from Medicaid agency in a large state noted that states might not have sufficient volume to stratify measures because population counts might be too small. They noted that they also encounter missing data with many "unknown" responses in the race and ethnicity data in their state. To improve data quality and completeness, the Workgroup member suggested educating the public on why these data are collected and how they are used to design programs. Another Workgroup member agreed, noting that the biggest barrier to stratifying Health Home Core Set measures is the denominator size, because the health home population is already a subset of the overall Medicaid population.

Reflecting on their experience working with states on the National Core Indicators (NCI) surveys—which are used to assess the performance of state programs serving people with intellectual and developmental disabilities—a Workgroup member noted that states have had to be mindful of ensuring that the samples they draw are representative of the racial and ethnic composition of the communities in which people live. As such, states have needed to increase the sample size for their NCI surveys to draw a representative sample and to report stratified results.

A Workgroup member suggested that stratifying the measures by language and geography may be easier because this information is more readily available and complete in Medicaid administrative data.

As a potential opportunity to help states calculate and report stratified Core Set measures for health home programs, a Workgroup member advocated for stratifying measures by race and ethnicity as part of the regular process of producing quality measures and suggested requiring stratification of the measures by race and ethnicity. The Workgroup member noted that in their previous role working in a state Medicaid agency, NCQA's development of standardized processes for categorizing race and ethnicity for a few measures enabled the state to stratify its measures as a part of its standard practice. The Workgroup member acknowledged the challenge of stratifying measures in small populations but highlighted a potential opportunity for MCOs to begin supplementing sociodemographic data for health home programs with data from other sources.

A Workgroup member representing a state Medicaid agency also shared that there are differences in how states define disability status and suggested technical assistance around how CMS thinks about disability status and the data sources for this information. Another Workgroup member similarly recognized the challenge of stratifying Health Home Core Set measures and proposed using a "crawl, walk, run" approach in which states start learning about the data and progress over time.

Cross-Cutting Themes During the 2023 Health Home Core Set Annual Review

Several cross-cutting themes emerged from the Workgroup's review of the measure suggested for addition to the Health Home Core Set, the discussion about measure gaps, and the conversations about enhancing data availability and advancing health equity. Dominant themes included the feasibility of reporting for states and the actionability of measures for health home programs, including the interplay between the two characteristics. The Workgroup also emphasized the strategic priority of measures for monitoring the overall quality of the Medicaid health home program.

Several Workgroup members noted that, because Health Home Core Set measures are collected and reported at the program level, the actionability of the data for real-time use by health home providers is paramount. For example, one Workgroup member noted that the use and usefulness of the data to providers are important for quality improvement so they can understand which health home enrollees are not getting care and then link them to care. This Workgroup member added that retrospective data, such as follow-up measures, are "too late" and do not allow providers to respond in a practical way to improve performance.

The interplay between the characteristics of feasibility and actionability was highlighted during the Workgroup discussion on gaps in the Health Home Core Set. Workgroup members noted that without a health home enrollee's consent, providers cannot share data related to sensitive conditions, such as SUD and HIV, with health home programs. Workgroup members further explained that when it is not feasible to obtain the data, health home care managers might not be able to identify health home enrollees with care gaps and close those gaps, thus minimizing the actionability of measures related to these conditions. As a result, one Workgroup member suggested reducing the number of SUD-focused measures in the Health Home Core Set due to actionability concerns. Another Workgroup member expressed concern about adding an HIV measure to the Health Home Core Set, noting that asking a health home program to be responsible for enrollees' HIV outcomes is challenging when the program cannot obtain the data needed to potentially influence those outcomes.

Emphasizing the strategic priority of measures, Workgroup members frequently expressed a desire to use the Health Home Core Set measures to understand the health care experiences of specific populations within a health home program, address social determinants of health, and advance health equity. Throughout discussions, some Workgroup members expressed an interest in stratifying Health Home Core Set measures by sociodemographic characteristics such as race, ethnicity, and geography. One Workgroup member advocated for mandatory stratification of the measures by race and ethnicity because such a mandate from CMS might prompt states to supplement their data systems or identify additional resources to stratify the measures. Several Workgroup members also suggested adding measures on screening and referral for social determinants of health to the Health Home Core Set to standardize measurements across programs and states.

Workgroup members expressed interest in using other data sources to improve the feasibility and viability of Health Home Core Set reporting. Some Workgroup members encouraged CMS's efforts to explore the use of alternate data sources to calculate the measures on behalf of states and suggested stratifying the Child and Adult Core Set measures by the health home population to minimize state reporting burden. However, Workgroup members acknowledged the current data limitations of identifying health home enrollees and attributing them to a specific health home program.

Lastly, to minimize the burden of reporting on states, several Workgroup members expressed a desire for a parsimonious measure set without duplicative measures. While discussing the *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions* measure, for example, Workgroup members questioned whether and how the measure overlapped with the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-HH), *Follow-Up After Emergency Department Visit for Mental Illness* (FUM-HH), and the *Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite* (PQI92-HH) measures currently in the Health Home Core Set. Other Workgroup members expressed a preference for removing a measure from the Health Home Core Set if another measure were added. The Workgroup's decision to not recommend *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions* reflects the Workgroup members' careful deliberation in recommending changes to the 2023 Health Home Core Set and thoughtful consideration about the future of the Health Home Core Set.

Suggestions for Technical Assistance to Support State Reporting of the Health Home Core Set

Workgroup members discussed opportunities for technical assistance to support states in reporting Health Home Core Set measures. The Workgroup made several suggestions:

- To facilitate the sharing of actionable data with health home providers about care gaps or follow-up needs among health home enrollees, a Workgroup member suggested having states send data to providers in a standardized template that could be adopted across all health home programs. States could use technical assistance to complete or populate the template with health home enrollee data so that providers receive this information in a standardized format.
- Two Workgroup members suggested that CMS could provide incentives to states to pilot measures that might be considered strategic priorities for the Health Home Core Set but that states have not yet tested. Alternatively, one Workgroup member suggested that Mathematica could test calculating Health Home Core Set measures using T-MSIS data and provide feedback to states on measure performance. They reasoned that given states' limited resources, having Mathematica test the measures and then share results could provide insight on the feasibility of using alternate data sources.

- One Workgroup member recommended providing state technical assistance or establishing a learning collaborative on improving performance on the measures. Another Workgroup member added that this type of technical assistance would be helpful from the state level, as Medicaid programs can look different across states.

Suggestions for Improving the Health Home Core Set Annual Review Process

Workgroup members suggested two opportunities to enhance the Health Home Core Set Annual Review process: (1) improving the Call for Measures process and (2) re-evaluating the agenda and format of the voting meeting.

Mindful of the reporting burden on states, the Call for Measures could include a reminder that if a measure is suggested for addition, Workgroup members should consider whether there is an existing measure that could be replaced or considered for removal.[22] A Workgroup member recommended that the Call for Measures encourage Workgroup members and federal liaisons to note not only the potential barriers for states in calculating the measure, but also to comment on how states might have approached these barriers. This Workgroup member added that states have worked hard to address and resolve barriers and sharing those experiences with other states would be beneficial.

To improve the structure of the voting meeting, a Workgroup member suggested moving the discussion of gaps and the future of the Health Home Core Set earlier in the annual review process, before the Call for Measures. They noted that this shift could inform the Workgroup's thought process as it considers which measures to suggest for removal or addition in a given year. Another Workgroup member suggested resurfacing measures that the Workgroup has already considered for potential consideration in the future. Lastly, three Workgroup members said they preferred in-person or video meetings, noting that these formats can improve engagement.

Next Steps

The 2023 Health Home Core Set Annual Review Workgroup considered one measure for addition to the 2023 Health Home Core Set, *Follow-Up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions*. The Workgroup discussed the measure and did not recommend it for addition to the 2023 Health Home Core Set. The Workgroup considered multiple factors when making its recommendation, including the feasibility for state reporting, alignment with strategic priorities, and actionability to drive improvement in care delivery and health outcomes for health home enrollees. The Workgroup did not consider any

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[22] Under the current Call for Measures process, Workgroup members submit a separate form for measures they suggest removing, on which they can offer the rationale for replacing them with another measure.

measures for removal. The Workgroup, therefore, did not recommend any changes to the 2023 Health Home Core Set.

During the discussion, Workgroup members expressed a desire to consider Health Home Core Set measures that focused on care coordination, care management, and health promotion. Workgroup members also discussed additional priorities for the Health Home Core Set, including engaging with health home providers to promote quality improvement; increasing data sharing between providers; and using alternate data sources, such as T-MSIS, to reduce reporting burden. Finally, Workgroup members acknowledged the challenges of stratifying the Health Home Core Set measures by race, ethnicity, geography, and other sociodemographic characteristics. Workgroup members identified this as a potential opportunity for technical assistance, acknowledging the challenges of stratification (particularly due to the small denominators and data quality issues for demographic data).

The draft report was made available for public comment from September 30, 2022 through October 28, 2022. No public comments were received.

CMS will review the final report to inform decisions about whether and how to modify the 2023 Health Home Core Set. Additionally, CMS will obtain input from federal agencies to ensure that the Health Home Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government. CMS will release the 2023 Health Home Core Set by December 31, 2022.

Appendix A:
2022 Health Home Core Set Measures

Exhibit A.1. 2022 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Quality Measures			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative or EHR
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, hybrid, or EHR
0034	NCQA	Colorectal Cancer Screening (COL-HH)*	Administrative or EHR[a]
0418**/ 0418e**	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
1768**	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)*	Administrative
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Administrative
Utilization Measures			
NA	CMS	Admission to an Institution from the Community (AIF-HH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative
NA	CMS	Inpatient Utilization (IU-HH)	Administrative

* This measure was added to the 2022 Health Home Core Set.

** This measure is no longer endorsed by NQF.

[a] The Colorectal Cancer Screening measure is also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Health Home Core Set reporting.

AHRQ = Agency for Healthcare Research and Quality; CMS = Centers for Medicare & Medicaid Services; EHR = electronic health record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

Exhibit A.2. Core Set of Health Home Quality Measures for Medicaid (Health Home Core Set), 2013–2022

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Quality Measures												
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	X	X	X	X	X	X	X	X	X	X
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	X	X	X	X	X	X	X	X	X	X
0034	NCQA	Colorectal Cancer Screening (COL-HH)[a]	--	--	--	--	--	--	--	--	--	X
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	X	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	X	X	X	X	X	X	X	X	X	X
1768*	NCQA	Plan All-Cause Readmissions (PCR-HH)	X	X	X	X	X	X	X	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)[b]	--	--	--	--	--	--	--	X	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)[c]	--	--	--	--	--	--	--	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)[d]	--	--	--	--	--	--	--	--	--	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-HH)[e]	X	X	X	X	X	X	X	X	--	--
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	X	X	X	X	X	X	X	X	X	X

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Utilization Measures												
0648	AMA/ PCPI	Care Transition – Timely Transmission of Transition Record (CTR-HH)[f]	X	X	X	X	X	X	--	--	--	--
NA	CMS	Admission to an Institution from the Community (AIF-HH)[g]	--	--	--	--	--	--	X	X	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	X	X	X	X	X	X	X	X	X	X
NA	CMS	Inpatient Utilization (IU-HH)	X	X	X	X	X	X	X	X	X	X
NA	CMS	Nursing Facility Utilization (NFU-HH)[g]	X	X	X	X	X	X	--	--	--	--

Notes: X = included in Health Home Core Set; -- = not included in Health Home Core Set. More information on 2022 updates to the Health Home Core Health Care Quality Measurement Set 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.

* This measure is no longer endorsed by NQF.

[a] The Colorectal Cancer Screening (COL-HH) measure was added to the 2022 Health Home Core Set to address gaps in care and health disparities and to align with the Adult Core Set.

[b] The Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH) measure was added to the 2020 Health Home Core Set to help states meet the new reporting requirements for states with an approved SUD-focused health home under Section 1945(c)(4)(B) of the SUPPORT Act and to align with the Adult Core Set.

[c] The Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH) measure was added to the 2020 Health Home Core Set to promote alignment across the Adult and Health Home Core Sets and to broaden the scope of SUD measures in the Health Home Core Set.

[d] The Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH) measure was added to the 2022 Health Home Core Set because it addresses priority areas of access and follow-up care for adults with mental health or SUDs.

[e] The Adult Body Mass Index Assessment (ABA-HH) measure was retired from the 2021 Health Home Core Set because it was retired by the measure steward

[f] The Timely Transmission of Transition Record (CTR-HH) measure was retired from the 2018 Health Home Core Set due to the low number of states reporting this measure over time and the challenges states faced in reporting the measure.

[g] The Admission to an Institution from the Community (AIF-HH) measure changed for FFY 2019 from a measure of Nursing Facility Utilization (NFU-HH) to a measure that includes multiple rates and is based on a broader definition of institutional admissions.

AHRQ = Agency for Healthcare Research and Quality; AMA = American Medical Association; CMS = Centers for Medicare & Medicaid Services; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PCPI = Physician Consortium for Performance Improvement; SUD = substance use disorder.

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