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Medicaid Health Home Core Sets Annual Review Workgroup:

Measures Suggested for Addition to the 2025 Health Home Core Sets

Measure Information Sheets
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MEASURE INFORMATION SHEET

HEALTH HOME CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SET

Measure Information	
Measure name	**Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2)**
Description	The percentage of Medicaid managed long-term services and supports (MLTSS) participants age 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements. Two performance rates are reported for this measure: (1) Care Plan with Core Elements and (2) Care Plan with Supplemental Elements. Two exclusion rates are also reported: (1) Participant Could Not be Contacted and (2) Participant Refused Care Planning.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Meaningful Measures area(s)	Chronic conditions
Measure type	Process
Addition of measure to which Core Set(s)?	1945 Health Home Core Set
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	The Adult Core Set includes the NCQA version of this measure: Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD). The CPU-AD measure also includes two performance rates: (1) Care Plan with Core Elements Documented and (2) Care Plan with Supplemental Elements Documented. Required exclusions are reported with the measure rate: (1) Could not be reached for care planning, and (2) Refusal to participate in care planning.

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Technical Specifications	
Ages	Age 18 and older as of the first day of the measurement year.
Data collection method	Case management record review.
Denominator	This measure is based on review of Medicaid MLTSS plan case management records from a systematic sample drawn from the eligible population.
Numerator	Two performance rates are included in the numerator. 1. *Care Plan with Core Elements.* Medicaid MLTSS participants who had a long-term services and supports comprehensive care plan with nine core elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Care Plan with Supplemental Elements.* Medicaid MLTSS participants who had a long-term services and supports comprehensive care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants).
Exclusions	Required exclusions are reported with the measure rates. Two exclusion rates are included.[1] 1. *Participant Could Not Be Contacted.* Medicaid MLTSS plan participants who could not be contacted to create a long-term services and supports comprehensive care plan within 120 days of enrollment (for new participants) or during the measurement year (for established participants). 2. *Participant Refused Care Planning.* Medicaid MLTSS plan participants who refused a comprehensive care plan.
Continuous enrollment period	A participant must be enrolled in a Medicaid MLTSS plan for at least 150 continuous days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For participants with multiple distinct continuous enrollment periods during the measurement year, use the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year.
Level of reporting for which specifications were developed	Plan-level.

[1] Exclusion rates are reported to illustrate portions of the intended measure population uncaptured in the performance rate. Medicaid MLTSS plan participants have the right to refuse to participate in care planning, and managed care plans may have difficulty contacting some participants.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual-2022-updated.pdf.
Information on testing or use at state Medicaid/CHIP level	The Workgroup Member (WGM) noted that Hawaii has used the measure. The measure is included in the Home and Community-Based Services (HCBS) Quality Measure Set for voluntary reporting by states and managed care plans (https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf). At this time, public reporting of the measure data is not required and, therefore, information on the measures included in the HCBS Quality Measure Set is not available.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM identified that the collection of data from a case management record review may be a barrier, limitation, or source of variation.

Actionability and Strategic Priority	
How measure contributes to measuring the overall national quality of health care in Medicaid health home programs, taken together with other Health Home Core Set measures	The WGM noted that a requirement for health home programs includes care coordination. This measure identifies the existence of, and timeliness of, a care plan developed to ensure patient-centered, coordinated, quality care for members receiving long-term services and supports.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM noted that the data source does not allow for stratification at this time. The measure steward confirmed that the measure is not currently stratified. The upcoming public comment period for this measure will inform updated measure specifications for MLTSS-2. Any changes would go into effect in January 2024.
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM stated that this measure assesses whether members identified as needing long-term services and supports have a care plan developed, based on their assessed needs, within 120 days of enrollment, and once established, at least once during the measurement year.

Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	The WGM indicated that to be included in the numerator, the care plan must meet nine core elements. Eight supplemental elements are also assessed. It includes member goals, a plan of care to meet medical needs, a plan of care to meet functional needs, a plan of care to meet the participant's needs because of cognitive impairment (documented whether there are or are not cognitive needs), a list of services and supports the member receives and how they receive them, care management follow-up, emergency care plans, contact information for family and friends, and an agreement to participate in the care plan. Supplemental elements include a plan to meet the mental health needs of the member, a plan to meet the member's social or community integration needs, duration of services, contact information for service providers, a plan to assess progress towards goals, documentation of barriers to achieving defined goals, point of contact for the member's care manager and contact information for the member's primary care physician and providers.
How measure can be used to monitor improvement	The WGM reported that this is a newer measure and results in Hawaii show room for improvement. Results can be trended over time. Medicaid health home programs and providers can directly influence improvement on this measure through contract requirements, and monitoring timeliness and completeness of care plans.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid beneficiaries	The WGM stated this measure was designed to assess quality of care for members that qualify for MLTSS in Medicaid. However, the WGM indicated that it also has potential to be used for health home programs.
Use of measure in other CMS programs	CMS HCBS Quality Measure Set, which is being considered for pilot use in select 1115 demonstrations.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM noted a potential barrier is if the state does not require managed care entities to use a case management system. The measure steward noted that the measure does not require electronic care systems. While the measure does require a review of case management records, these case records can be electronic or paper-based.
Summary of prior Workgroup discussion	This measure has not been discussed previously by the Workgroup.

Other	The measure will be undergoing a public comment period in 2023. Following the close of the public comment period, updated measure specifications for MLTSS-2 are anticipated to be publicly posted on CMS's website later this year. These changes would go into effect January 2024 and would be available in time for 2025 Core Set Reporting. The measure is currently only specified for use in managed LTSS plans and would need to be adapted for use in health home programs in states with a fee-for-service delivery system. New fee-for-service LTSS measures will be undergoing a public comment period in 2023. Following the close of the public comment period, fee-for-service measure specifications for LTSS-2 are anticipated to be publicly posted on CMS's website later this year. These changes would go into effect January 2024 and would be available in time for 2025 Core Set Reporting.

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Measure That Will Not Be Reviewed

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SETS

Measure Information	
Measure name	**Screening for Social Drivers of Health (SDOH-1)**
Description	Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Meaningful Measures area(s)	Wellness and prevention
Measure type	Process
Addition of measure to which Core Set(s)?	1945 Health Home Core Set
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative, hybrid, or electronic health records (EHR).
Denominator	Number of patients 18 years and older on date of encounter.
Numerator	Number of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Screening must be done using a standardized health-related social needs (HRSN) screening tool.
Exclusions	Not specified.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Provider-level, program-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	Specifications for the measure are available at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2215/2023+Clinical+Quality+Measure+Specifications+and+Supporting+Documents.zip (CMS measure #487).
Information on testing or use at state Medicaid/CHIP level	There is no evidence that this measure has been tested or is in use for reporting at the state level by Medicaid and CHIP agencies. However, HRSN screening was required by the Accountable Health Communities model, which required participation by state Medicaid agencies.[1] In addition, 24 Medicaid programs required their MCOs to screen enrollees for social needs as of FY 2021.[2] The SDOH-1 measure is required for hospitals reporting to the Inpatient Quality Reporting (IQR) program beginning in 2024.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup Member (WGM) indicated that codes are included in the specification, including standard CPT codes, telehealth modifiers, and HCPCS M codes, which would allow providers to indicate whether screening occurred. The M codes (M1207-1208) were approved by CMS for use in Medicare and are available for state Medicaid programs to activate.[3] States would need to activate the two M codes for use in Medicaid. The WGM noted the measure requires use of standardized tools, and the specification identifies and provides links to five standardized HRSN/SDOH screening tools. The WGM commented that the measure focuses on documentation that screening occurred. A separate measure, not under consideration for the Health Home Core Set, addresses the Screen Positive Rate for Social Drivers of Health (SDOH-2). Finally, the WGM suggested that technical assistance (TA) would help alleviate variation across states, such as encouraging state activation of the M codes, promoting provider use of the codes, and identifying strategies for standardized screening.

Actionability and Strategic Priority	
How measure contributes to measuring the overall national quality of health care in Medicaid health home programs, taken together with other Health Home Core Set measures	The WGM commented that there currently is no SDOH measure in the 1945 Health Home Core Set. The Workgroup has identified that as a gap in the past. The WGM indicated that this SDOH measure was recently included in the MIPS CQMs and the IQR program and represents the simplest way to add a measure to the Health Home Core Set that fills the gap. The WGM added that the measure's use in MIPS can be seen as a foundation facilitating its use more widely after 2025. The contribution to overall national quality of health care in Medicaid and CHIP is provided by CMS in the Rationale and Clinical Recommendation Statements in the MIPS specification, which also identifies the measure as "High Priority." Among other things, the MIPS Rationale states "[a]n estimated 20 percent of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors referred to as drivers of health (DOH)."[4] The WGM indicated there is no better place than the Health Home Core Set to integrate a screening measure related to SDOH, given the role of health homes in coordinating care for individuals with complex needs.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM noted stratification should be possible with administrative data to the extent Medicaid data are relatively complete and the variables are available in the data source. If the data source is EHR or hybrid, stratification may also be possible if the relevant variables are available.
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM stated that the measure addresses screening for SDOH and, if incorporated into the 1945 Health Home Core Set, would encourage identification of health home enrollees with such needs and facilitate next steps in addressing those needs. The measure would permit assessment of progress in screening for these critical impediments to use of health care. The Medicaid population is among those most likely to experience SDOH deficits by virtue of economic circumstances and other sociodemographic characteristics. Among the CMS Strategic Pillars, this measure addresses both advancing equity and driving innovation. In the HHS Strategic Plan for FY 2022–2026, it addresses the goals of equitable access and strengthening social well-being.[5]

Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	The WGM indicated that there is considerable evidence that neighborhood deprivation is associated with hospital readmissions for many conditions, such as hospital readmissions after colon and rectal surgery.[6] The WGM cited evidence that screening for SDOH and subsequent connection to services can lead to improvement in the quality of health care delivery and outcomes (e.g., related to emergency department use in the CMMI Accountable Health Communities model initial evaluation). It is not possible, however, to directly link this specific measure to those outcomes. The WGM noted that CMS supported adoption of this measure for the MIPS program with evidence that 80% of health outcomes are linked not to medical care but to SDOH.[2]
How measure can be used to monitor improvement	The WGM noted the measure can be used to improve health care delivery via rates of systematic screening using standardized screening tools. The screening needs to happen if interventions to improve outcomes are going to be implemented more widely and measured. The WGM added that outcomes cannot be measured unless screenings are widely implemented and follow-up interventions occur. Adoption of the SDOH-1 measure as a health home measure will push the screening, allow monitoring of the screening, and lay the groundwork for connections to needed social services. The WGM suggested that the SDOH-1 measure could be used to assess trends over time in health home program performance and progress with regard to SDOH screening. Finally, the WGM suggested that state Medicaid programs can directly influence improvement on this measure of SDOH screening. They can do so by making the specified codes available and providing technical assistance to providers to encourage screening and to begin the process of better identifying resources to which beneficiaries can be referred. These supports, in turn, will enable health home providers to screen for SDOH (which is measured by SDOH-1) and connect enrollees with the social resources they need.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid beneficiaries	The WGM stated the effects of SDOH on health and wellbeing are experienced across conditions. A recent study from a Massachusetts Medicaid ACO included 27,413 patients (pediatric and adult), across 114 primary care practices, who completed an SDOH screening questionnaire between February 2019 and February 2020.[7] The questionnaire inquired about risk factors related to food, housing, medication, transportation, utilities, family care, employment, and education, as well as social need across those factors. Those screened represented 87.7% of those eligible to be screened and 25.3% were ACO beneficiaries. Of those screened, 44.6% were positive for ≥ 1 social risk factor and 9.6% for ≥ 3 risks. The WGM added that the initial evaluation of the CMMI Accountable Health Community model looked at the same five social needs included in the proposed measure; they found food insecurity in 69% of one group of beneficiaries and identified other common needs such as housing, transportation, and utilities.[8]
Use of measure in other CMS programs	• Merit-Based Incentive Payment System (MIPS) CQMs beginning in 2023 • Hospital IQR Program measures, voluntary in 2023 and required beginning in 2024 • This measure may be incorporated into the joint SAMHSA, CMS, and ASPE Behavioral Health Clinic (BHC) measures being revised in 2023, for use by Certified Community Behavioral Health Clinics (CCBHCs)
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM said that states would need to ensure that the two HCPCS M codes are activated for their Medicaid programs and recommended that state Medicaid programs provide technical assistance to ensure that the codes are used.
Summary of prior Workgroup discussion	This measure has not been discussed previously by the Workgroup.

Other	The WGM commented that implementing a well-specified SDOH measure is an urgent need. The lack of standardized SDOH measures has been identified as a gap over the years, and the WGM suggested that implementing an SDOH measure for the Health Home Core Set should be a priority. The WGM added that Medicaid enrollees tend to be low-income, often experiencing intersectionalities, such as unstable housing or food insecurity. The WGM said that CMS and states cannot measure progress in addressing SDOH or disparities without standardized measures to assess existing efforts. The WGM noted that a federally standardized measure would address concerns that Medicaid programs, MCOs, and ACOs use SDOH screening and measure results differently. In October 2020, one study reviewed efforts by four Medicaid agencies to develop approaches for their ACOs or MCOs.[9] The states differed in their use of screening tools and the way they measured screening, which indicates a need for a common measure. The screening approaches coalesced around food, housing, and transportation, and to a lesser extent, utilities, interpersonal safety, and immediate need. Finally, the WGM stated that the CMMI Accountable Health Community (AHC) model was focused on screening for the same five social drivers as those included in this measure.[10] Thus, screening occurred in organizations across many states and the extent of screening and need was measurable as part of the independent evaluation. The WGM indicated that this provides evidence that the screening can be done, and the information can be captured. Moreover, the WGM indicated there is a growing need for a common measure across initiatives, including states seeking or receiving authorization to address SDOH via Section 1115 demonstrations.

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Citations

[1] https://innovation.cms.gov/innovation-models/ahcm.

[2] https://www.kff.org/other/state-indicator/states-reporting-social-determinant-of-health-related-policies-required-in-medicaid-managed-care-contracts/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] https://www.cms.gov/files/zip/january-2023-alpha-numeric-hcpcs-file.zip.

[4] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2215/2023+Clinical+Quality+Measure+Specifications+and+Supporting+Documents.zip.

[5] https://www.hhs.gov/about/strategic-plan/2022-2026/index.html.

[6] https://scholars.uthscsa.edu/en/publications/association-of-socioeconomic-area-deprivation-index-with-hospital.

[7] Schiavoni, K. H., Helscel, K., Vogeli, C., Thorndike, A. N., Cash, R. E., Camargo, C. A., & Samuels-Kalow, M. E. (2022), Prevalence of social risk factors and social needs in a Medicaid Accountable Care Organization (ACO). BMC Health Services Research, 22(1), 1–9.

[8] https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.

[9] https://www.shvs.org/wp-content/uploads/2020/10/Developing-a-SRF-Screening-Measure_Issue-Brief.pdf.

[10] https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.