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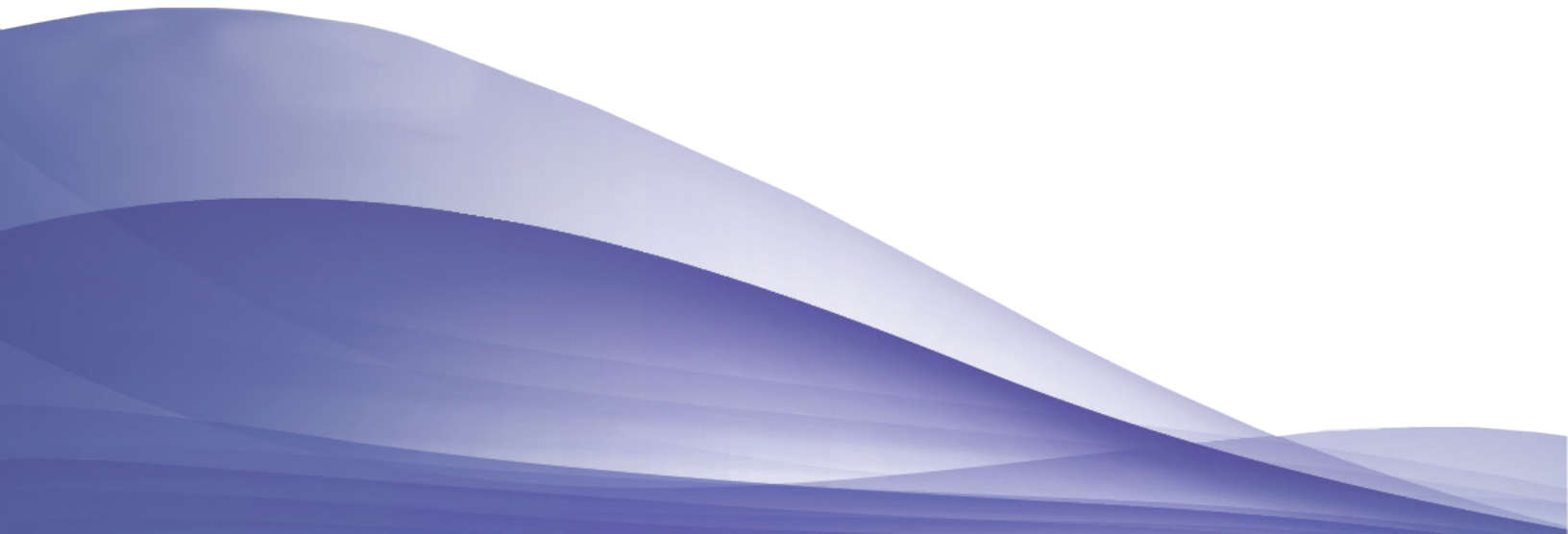
Recommendations for Improving the Medicaid Health Home Core Set of Health Care Quality Measures

Summary of a Multistakeholder Review of the 2022 Health Home Core Set

Final Report

December 2021



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Acronyms

ACEs	Adverse childhood experiences
AMB-HH	Ambulatory Care: Emergency Department (ED) Visits
AOD	Alcohol and other drug
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CDF-HH	Screening for Depression and Follow-Up Plan
DAS	Differential Ability Scales
ECDS	Electronic Clinical Data Systems
ED	Emergency department
EHR	Electronic health record
EQRO	External quality review organization
FFY	Federal fiscal year
FUA-HH	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUH-HH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-Up After Emergency Department Visit for Mental Illness
HbA1c	Hemoglobin A1c
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health information exchange
IET-HH	Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment

MCO	Managed care organization
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PHQ	Patient Health Questionnaire
PQI	Prevention Quality Indicator
SPA	State Plan Amendment
SED	Serious emotional disturbance
SMI	Serious mental illness
SUD	Substance use disorder
TA	Technical assistance

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 April 2021, 21 states[1] have 37 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 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 through a uniform set of measures and to use the measures to drive improvement in the quality of care. 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 numerous stakeholders, including but not limited to state Medicaid agency representatives, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2022 Medicaid Health Home Core Set Annual Review Stakeholder Workgroup (Workgroup). This is the first multistakeholder annual review of the Health Home Core Set. The Workgroup included 13 members, who represented a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover for a list of the Workgroup members).

The Workgroup was charged with assessing the 2021 Health Home Core Set and recommending measures for removal or addition, in order to strengthen and improve the Health Home Core Set for 2022. Workgroup members were asked to suggest, discuss, and vote on the measures based

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

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

[3] A Medicaid and CHIP state plan is an agreement between a state and the federal government describing how the state administers its Medicaid and CHIP programs. 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 SPAs 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.

on whether they could 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 2022 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. Health home programs 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.
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 health home program enrollees.
2. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
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 health home programs, 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 FFY 2024.
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 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.
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.

Exhibit ES.1 *(continued)*

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 health home program enrollees.
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 health home programs, 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.
3.	All health home programs should be able to produce the measure by FFY 2024, including all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually on August 17 and August 18, 2021 to review three existing Health Home Core Set measures suggested for removal from the 2021 Health Home Core Set and five measures suggested for addition. The eight measures were presented, discussed, and voted on starting with measures suggested for removal followed by measures suggested for addition. 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.

In summary, the Workgroup recommended the following:

- **Removal of 2 measures** out of a total of 3 measures suggested for removal
- **Addition of 2 measures** out of a total of 5 measures suggested for addition

Exhibit ES.2 shows the measures the Workgroup recommended for removal from and addition to the 2022 Health Home Core Set.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2022 Health Home Core Set

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Removal from the Health Home Core Set		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	National Committee for Quality Assurance (NCQA)	0004
Screening for Depression and Follow-Up Plan (CDF-HH)	Centers for Medicare & Medicaid Services (CMS)	0418*/0418e*
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Mental Illness	NCQA	3489
Colorectal Cancer Screening	NCQA	0034

* This measure is no longer endorsed by NQF.

This report describes the 2022 Health Home Core Set Annual Review Workgroup's review process, summarizes the Workgroup's recommendations for improving the Health Home Core Set, and presents the public comments submitted on the draft report. CMCS will review the final report to inform decisions about whether and how to modify the 2022 Health Home Core Set. Additionally, CMCS will obtain stakeholder 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 2022 Health Home Core Set in early 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. 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).[5] 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.[6] As of April 2021, 21 states[7] have 37 approved health home programs, with some states submitting multiple SPAs to target different populations.[8,9]

To qualify for Medicaid health home services, beneficiaries must be diagnosed with two chronic conditions, one chronic condition and risk for a second, or a serious mental illness. Section 1945(h)(2) of the Social Security Act defined "chronic condition" to include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and being overweight (body mass index over 25). Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.[10]

Additionally, Medicaid health home programs must provide six core services to enrollees including:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care and follow-up
5. Individual and family support services
6. Referral to community and social services, using health information technology

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

[6] A Medicaid and CHIP state plan is an agreement between a state and the federal government describing how the state administers its Medicaid and CHIP programs. 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 SPAs is available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

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

[8] A list of all approved health home SPAs as of April 2021 is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-spa-overview.pdf.

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

[10] https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

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 through a uniform set of measures and to use the measures to drive improvement in the quality of care. 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 numerous stakeholders, including but not limited to state Medicaid agency representatives, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2022 Medicaid Health Home Core Set Annual Review Workgroup (Workgroup). [11,12] This is the first multistakeholder annual review of the Health Home Core Set. The Workgroup included 13 members, who represented a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover for a list of the Workgroup members).

The Workgroup was charged with assessing the 2021 Health Home Core Set and recommending measures for removal or addition in order to strengthen and improve the Health Home Core Set for 2022. 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 2022 Health Home Core Set Annual Review process, summarizes the Workgroup's recommendations for improving the Health Home Core Set, and includes public comments on the Workgroup recommendations.

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

[12] Mathematica also supported CMCS by convening the Child and Adult Core Set Annual Review Workgroup to review and strengthen the 2022 Child and Adult Core Sets. More information about the annual multistakeholder review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview.

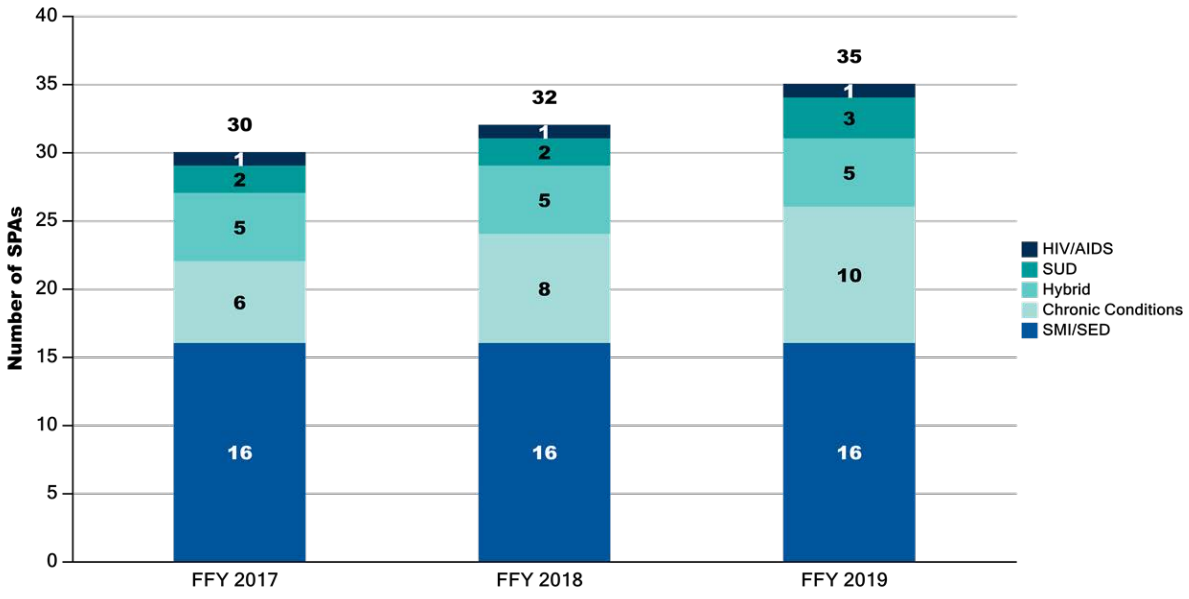
Overview of the Health Home Core Set

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 federal fiscal year (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 payment, Medicaid health home providers are required to report quality measures to the state, and states are expected to report these measures to CMS (42 U.S.C. Section 1945(g)). It is important to note that states are expected to report all Health Home Core Set measures, regardless of the health home program focus area, and that states are expected to report the measures separately for each of their SPAs. The 2021 Health Home Core Set includes 11 measures, including 8 quality measures and 3 utilization measures. Appendix A contains more information about the 2021 Health Home Core Set measures.

Health Home Core Set Reporting

CMS released performance and trending data for the Health Home Core Set for the first time for FFY 2019. Exhibit 1 shows the distribution of health home programs by target population from FFY 2017 to FFY 2019. The number of approved health home SPAs has increased over time. In FFY 2019, there were 16 health home programs serving individuals with serious mental illness, and an additional 10 programs serving individuals with chronic conditions. There are also five "hybrid" SPAs, which refer to health home programs that have two or more focus areas.

Exhibit 1. Number of Health Home SPAs by Target Population, FFY 2017–FFY 2019



Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, December 2020. Available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2020-health-home-core-set-chart-pack-ffy-2019.pdf.

Notes: Hybrid SPAs refer to SPAs that have two or more areas of focus (e.g., SUD and SMI/SED).

CMS publicly reports data for Health Home Core Set measures that were reported by at least 15 SPAs and met CMS standards for data quality.[13] Highlights for FFY 2019 Health Home Core Set reporting[14] include the following:

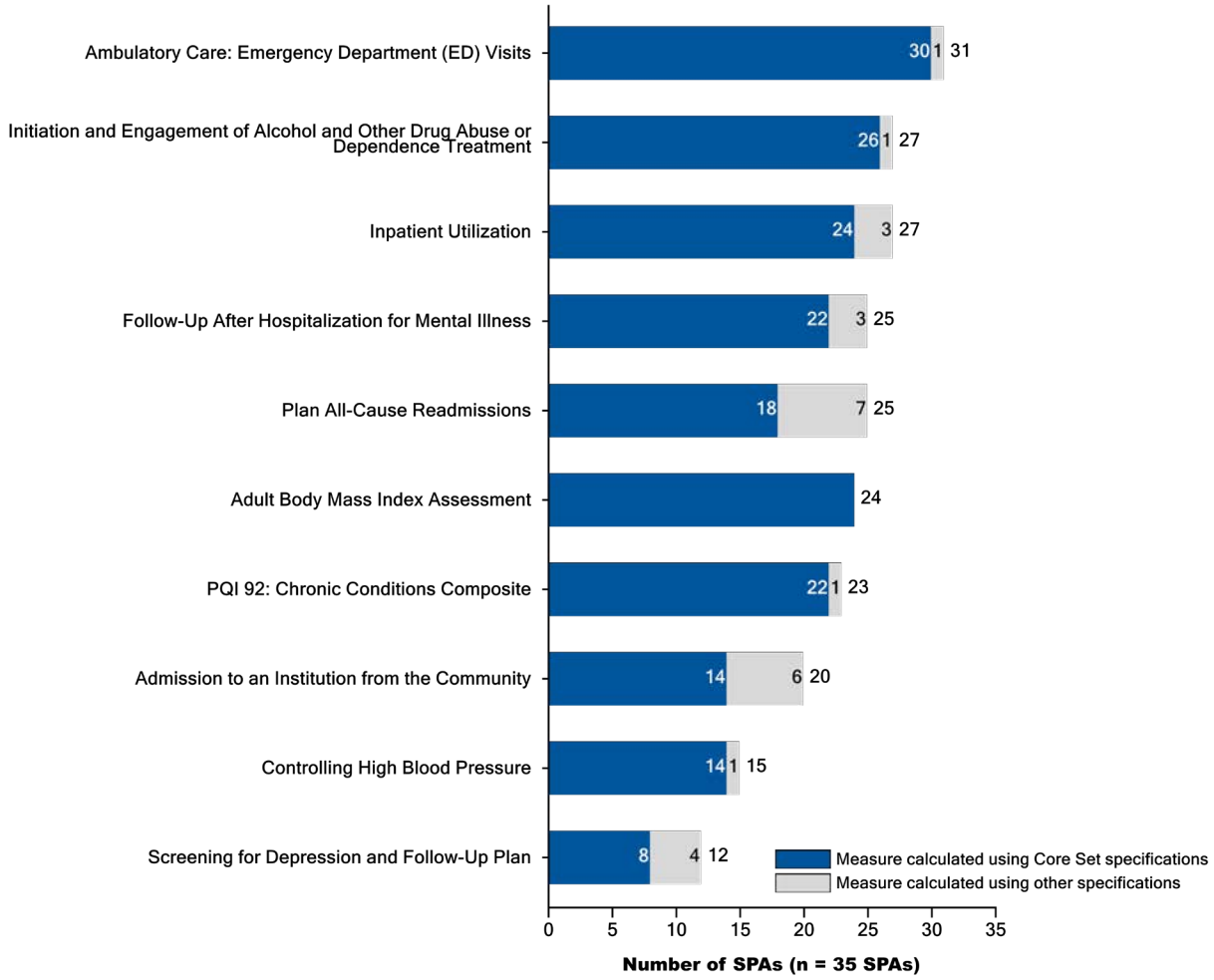
- Of the 35 SPAs expected to report Health Home Core Set measures for FFY 2019, 31 SPAs reported at least one measure. The other four SPAs did not submit data in time to be included in publicly reported data.
- SPAs reported a median of 7 of the 10 Health Home Core Set measures for FFY 2019.
- Seven measures were reported by at least two-thirds of the SPAs expected to report for FFY 2019.
- Reporting remained consistent or increased for 24 of the 25 SPAs that reported for all three years from FFY 2017 to FFY 2019.
- Reporting increased for all 9 measures included in both the FFY 2017 and FFY 2019 Health Home Core Sets.

Exhibit 2 summarizes the number of SPAs reporting the Health Home Core Set measures for FFY 2019. The most commonly reported measures for FFY 2019 included the Ambulatory Care: Emergency Department (ED) Visits measure, the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure, and the Inpatient Utilization measure. The least frequently reported measures for FFY 2019 included the Screening for Depression and Follow-Up Plan measure, the Controlling High Blood Pressure measure, and the Admission to an Institution from the Community measure.

[13] 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-jan-2021.pdf.

[14] 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. A chart pack summarizing FFY 2019 Health Home Core Set results is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2020-health-home-core-set-chart-pack-ffy-2019.pdf.

Exhibit 2. Number of SPAs Reporting the Health Home Core Set Measures, FFY 2019



Source: Centers for Medicare & Medicaid Services, Medicaid and CHIP Core Set Technical Assistance and Analytic Support Program, December 2020. Available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2020-health-home-core-set-chart-pack-ffy-2019.pdf.

Notes: This chart includes all Health Home Core Set measures that SPAs reported for the FFY 2019 reporting cycle. Unless otherwise specified, SPAs used Health Home Core Set specifications to calculate the measures. Some SPAs calculated Health Home Core Set measures using "other specifications." Measures were denoted as using "other specifications" when the SPA deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

State Challenges with Reporting the Health Home Core Set Measures

Understanding state challenges with reporting the Health Home Core Set measures is important to 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 2019 was lack of access to data to calculate the measure. States' reasons for lack of access to data focused on availability of information from sources other than claims or encounter data, such as medical records for chart abstraction. Another common barrier was lack of required codes in administrative data. In addition, small

health home populations and continuous enrollment requirements limited the number of health home enrollees that were eligible for some of the measures.

Workgroup members were provided with information about states' reasons for not reporting the existing Health Home Core Set measures as well as a summary of technical assistance (TA) efforts to improve state reporting on the least-reported measures.[15] These findings informed the Workgroup's discussion of the feasibility of reporting existing measures suggested for removal from the Health Home Core Set and calculating new measures suggested for addition.

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

CMCS 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 performance over time.[16] Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners in collecting, reporting, and using the Health Home Core Set measures to drive improvement in Medicaid health home programs. These goals include maintaining or increasing the number of SPAs that report the Health Home Core Set measures, maintaining or increasing the number of measures reported by each SPA, and improving the quality and completeness of the data reported.[17] CMCS also 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 states. 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 TA mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars.

To provide context for the Health Home Core Set Review, the Workgroup members discussed their experience using the Health Home Core Set measures for quality measurement and improvement. Key themes from the discussion focused on the importance of aligning measures across Medicaid and CHIP, analyzing and sharing results with health home providers, providing opportunities for technical assistance, and acknowledging the challenges of using the measures for quality improvement. These perspectives provided important context and level-setting for the Workgroup members' discussion of individual measures under consideration for addition to or removal from the Health Home Core Set. Many of the themes that emerged from this discussion were also surfaced during discussions of the individual measures.

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[15] Health Home Core Set measure summaries are available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set-summaries-ffy-2019.zip.

[16] CMCS publicly reports information on SPA performance on the Health Home Core Set annually through chart packs, measure-specific tables, facts sheets, and other resources. 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.

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

Aligning Measures across Medicaid and CHIP

Workgroup members discussed the importance of aligning the Health Home Core Set measures with state priorities and other state reporting efforts. One Workgroup member discussed how managed care organizations (MCOs), which are the lead entities in their health home program, are required to develop and report on a set of performance measures, which can either be comprised of measures from the Health Home Core Set or measures that may impact performance on the Health Home Core Set measures. Another Workgroup member noted that measures that align with state priorities can be best leveraged through work with MCOs, providers, and other stakeholders to drive improvement in performance. Another Workgroup member reflected a similar experience, noting that their MCOs are working to align measures across MCOs so health homes can narrow their focus. Several other Workgroup members highlighted the importance of aligning Health Home Core Set measures with measures in the Child and Adult Core Sets and in other care delivery arrangements, like accountable care organizations, so that quality improvement efforts can be aligned across Medicaid and CHIP.[18]

Analyzing and Sharing Results with Health Home Providers

All Workgroup members discussed the role of analyzing Health Home Core Set measure results and sharing the data with health home providers for the purpose of quality improvement. One Workgroup member noted that their state uses analytics to identify high utilizers and determine their diagnoses. This information helps their state understand what processes can be improved to impact performance on the measures. Another Workgroup member noted that their state provides quarterly performance data on the Health Home Core Set and other quality measures to health home providers. They stratify the data by different subpopulations, programs, or conditions so health homes can use the data for quality improvement. The state also establishes benchmarks for the measures, provides improvement targets for health homes, and is working to identify additional opportunities to provide the data to health homes and consumers in accessible and actionable formats. Another Workgroup member concurred that stratification of measures by demographic characteristics, such as race or age, is important because it allows states to focus on opportunities for improvement, especially as states increasingly shift their attention to the social determinants of health.

Providing Opportunities for Technical Assistance

Two Workgroup members spoke about the importance of providing opportunities for technical assistance to help improve performance on the measures. For example, one Workgroup member discussed using a learning collaborative model to engage health homes in using the Health Home

[18] Information about the Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Information about the Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

Core Set measures, including monthly technical assistance webinars for health home programs to help them improve performance on the measures. Another Workgroup member indicated that their health homes and MCOs have formed a collaborative group that meets regularly to focus on a range of issues related to quality measurement and performance.

Acknowledging the Challenges of Using the Measures for Quality Improvement

Workgroup members also discussed challenges with using the Health Home Core Set for quality improvement. One challenge they mentioned is the variety of populations being served by health home programs at any given time, which means that previous performance might not always reflect the current health home population. Workgroup members also noted several data-related considerations, including (1) feasibility challenges related to the impact of the smaller population size of health home programs on reliability and precision of the measures, (2) mindfulness about health homes' capacity for reporting given the resources required to collect and report measures, and (3) the extent to which measure results across health home programs may reflect differences in outcomes versus the sophistication of each state's data system.

Workgroup members also reflected on the types of measures to include in the Health Home Core Set that could be useful for quality improvement. The discussion focused on measures that (1) can be used to inform programmatic and policy decisions, (2) are actionable and address strategic priorities for health homes, (3) can be impacted by effective care coordination, and (4) are generally within the control of the health home to impact performance.

Finally, several Workgroup members commented that a goal of the health home program is to achieve cost savings and using quality measures to demonstrate more effective care (such as reduced inpatient stays and ED visits) in health home populations has been difficult because it is a higher-needs population.

Description of the 2022 Health Home Core Set Annual Review Process

This section describes the 2022 Health Home Core Set Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2022 Health Home Core Set Annual Review included 13 voting members from state Medicaid agencies and other organizations from across the country. The Workgroup was selected through a Call for Nominations issued on February 12, 2021. The Workgroup members for the 2022 Health Home Core Set Annual Review are listed on the inside front cover of this report.

The 2022 Health Home Core Set Annual Review Workgroup members offered methodological 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 were asked 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.

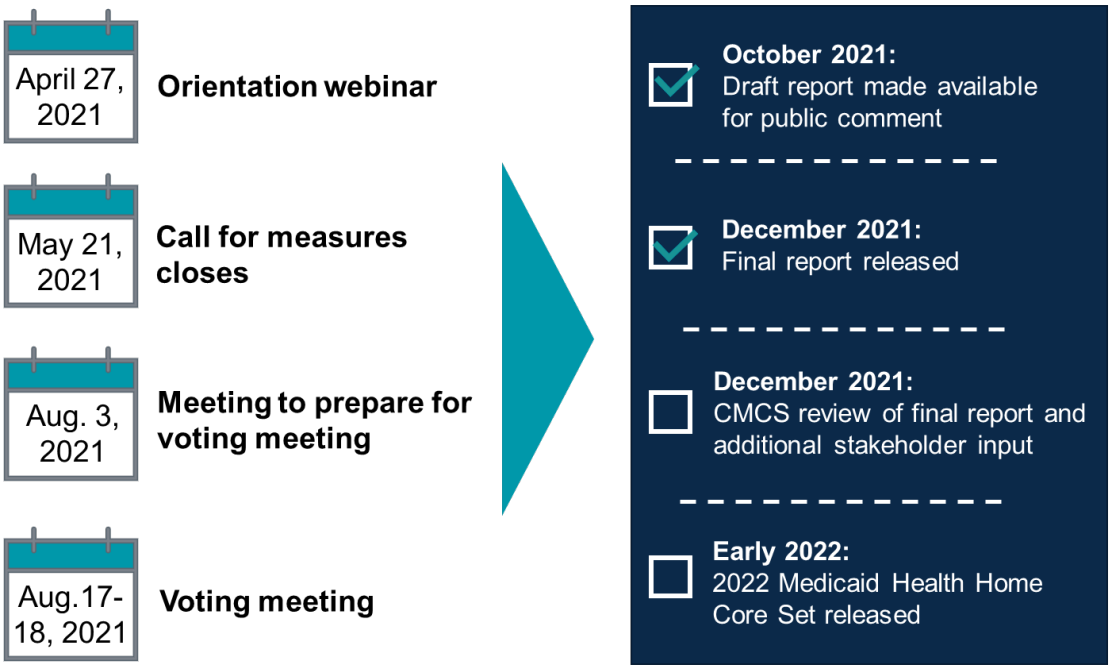
The Workgroup also included nonvoting federal liaisons, who represented six agencies (see front cover). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other agencies to collect, report, and use the Health Home Core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

Workgroup Timeline and Meetings

As shown in Exhibit 3, Mathematica held webinars in April 2021 and August 2021 to orient the Workgroup members to the review process and to prepare them for the 2022 Health Home Core Set Annual Review voting meeting, which was convened virtually in August 2021. All meetings were open to the public, and public comment was invited during each meeting. The draft report summarizing the Workgroup recommendations was released on October 8, 2021, and available for public comment until November 5, 2021. This final report incorporates public comments in Appendix D. CMCS will review the final report and obtain stakeholder input from federal

agencies to inform decisions about whether and how to modify the 2022 Health Home Core Set. CMCS will release the 2022 Health Home Core Set in early 2022.

Exhibit 3. Milestones for the 2022 Health Home Core Set Annual Review



Orientation Webinar

During the orientation webinar on April 27, 2021, Mathematica outlined the Workgroup charge, introduced the Workgroup members, and provided background on the Health Home Core Set.

After providing an overview of the process for the 2022 Health Home Core Set Annual Review, Mathematica described the additional stakeholder input that would be obtained during the 2022 Annual Review process, including input from federal partners and internal stakeholders within CMS.

Workgroup Charge

The Medicaid Health Home Core Set Stakeholder Workgroup for the 2022 Annual Review is charged with assessing the 2021 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.

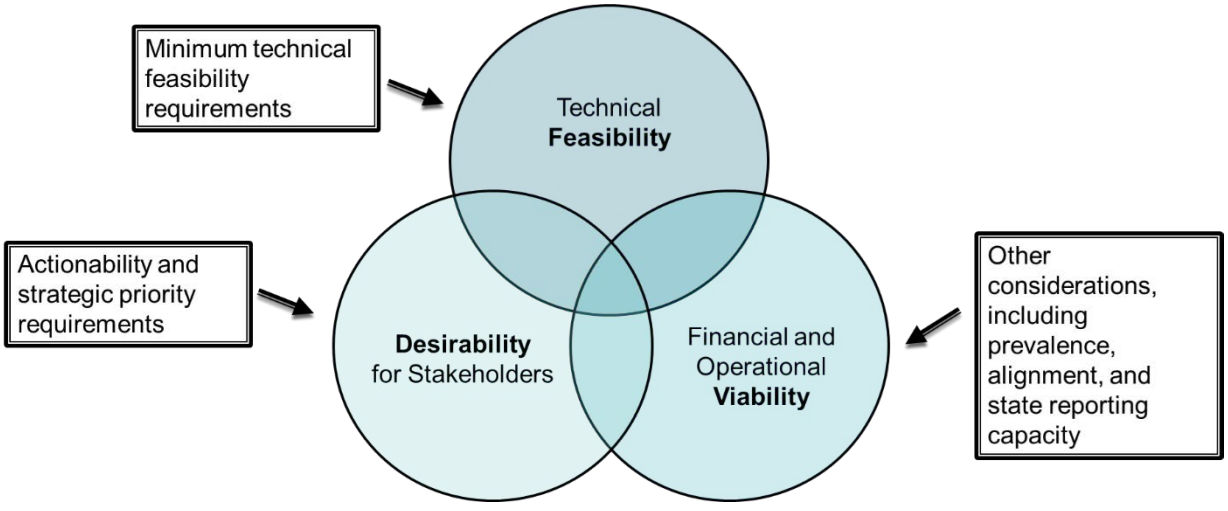
Mathematica also explained the Call for Measures process, through which Workgroup members suggest measures for addition to or removal from the Health Home Core Set. Mathematica asked Workgroup members to balance three interdependent components when considering measures

for addition or removal: (1) the technical feasibility of measures, (2) the desirability of measures for stakeholders, 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 shown in Exhibit 4, 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; and ability to produce consistent calculations across health home programs
- **Actionability and strategic priority requirements:** Contributes to estimating the overall program-level quality in Medicaid health home programs together with other Health Home Core Set measures, and can be used to perform comparative analyses; addresses a strategic priority for improving health care delivery and outcomes; and assesses state progress in improving health care delivery in health home programs
- **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 and/or the Child and Adult Core Sets; and capacity for all health home programs to report the measure by 2024

Exhibit 4. Framework for Assessing Measures for the 2022 Health Home Core Set



Call for Measures for Addition to or Removal from the Health Home Core Set

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 2022. Workgroup members used an online form to submit their suggestions for addition or removal, along with the following information:

- Rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for addition or removal
- Whether the removal of a measure would leave a gap in the Health Home Core Set
- Whether other measures were proposed to replace measures suggested for removal
- Whether measures suggested for addition were intended to replace current Health Home Core Set measures

The Workgroup members and federal liaisons suggested three measures for removal and five measures for addition. Two other measures were suggested for addition; they were not reviewed at the voting meeting because they were withdrawn by the Workgroup member. The Call for Measures specified that measures could only be considered in their specified form and not modified for Health Home Core Set reporting. The Workgroup member who suggested the two measures indicated that they would need to be modified for the Health Home Core Set but are worthwhile measure concepts for consideration by the Workgroup (housing status and oral evaluation). As a result, these measure concepts were included in the discussion of gaps, but they were not voted on.

Please refer to Appendix B for the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2022 Health Home Core Set.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on August 3, 2021. To help Workgroup members prepare for the discussion at the 2022 Annual Review meeting, Mathematica shared a list of the three measures to be considered for removal, the five measures to be considered for addition, and the two measures suggested for addition but later withdrawn by the Workgroup member.

Mathematica provided guidance to the Workgroup about how to prepare for the discussion of the measures at the August voting meeting, including the criteria that Workgroup members should consider for recommending measures for addition to or removal from the Health Home Core Set and the resources available to facilitate their review. These resources included detailed measure information sheets for each measure, a worksheet to record questions and notes for each measure, measure summary sheets, 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 responsible for reviewing all materials related to the measures; completing the measure worksheet; and coming to the Annual Review meeting prepared with notes, questions, and preliminary votes on each measure proposed for removal or addition.

2022 Health Home Core Set Annual Review Meeting

The 2022 Health Home Core Set Annual Review voting meeting took place virtually on August 17 and 18, 2021. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

Workgroup members discussed measures suggested for removal first, followed by measures suggested for addition. For each measure discussed, Mathematica noted the key technical specifications of each measure proposed for removal or addition and summarized the rationale that Workgroup members provided for suggesting the measures.

Mathematica then facilitated a discussion of the measures being reviewed. After presentation of a set of measures, Mathematica sought comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. Workgroup discussion was followed by an opportunity for public comment on the measures being discussed.

Voting took place after each Workgroup discussion and opportunity for public comment. Mathematica facilitated the voting on the measures suggested for removal or addition. Workgroup members voted electronically through a secure web-based polling application during specified voting periods. Workgroup members who experienced technical difficulties with the voting tool were permitted to submit votes through the webinar question and answer (Q&A) widget, or via email. Mathematica presented the voting results immediately after each vote and announced if the results met the two-thirds threshold for the measure to be recommended for removal from or addition to the Health Home Core Set.

For each measure suggested for removal, Workgroup members could select either "Yes, I recommend removing this measure from the Health Home Core Set" or "No, I do not recommend removing this measure from the Health Home Core Set." For each measure suggested for addition, 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."

Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted based on the number of eligible Workgroup members present for each measure vote. No fewer than 11 of the 13 Workgroup members participated in a given vote.

Following voting on all the measures suggested for addition or removal, 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 is presented later in the report.

Workgroup Recommendations for Improving the 2022 Health Home Core Set

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

To focus the Call for Measures for the 2022 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 Core Set in three areas: (1) minimum technical feasibility requirements, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

Mathematica instituted a preliminary screening process to ensure that measures discussed by the Workgroup adhered to a set of minimum technical feasibility criteria, including that detailed technical specifications were available for calculating the measures and that the measures had been tested or used by state Medicaid and/or CHIP programs.

Exhibit 5. 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. Health home programs 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.
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 health home program enrollees.
2. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
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 health home programs, 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 FFY 2024.

Exhibit 5 *(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 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.
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 health home program enrollees.
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 health home programs, 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.
3. All health home programs should be able to produce the measure by FFY 2024, including all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

In addition to the criteria considered for removal or addition, Mathematica also noted other factors the Workgroup should consider. These include the following:

- Alignment with current measures in CMS's Medicaid and CHIP Child and Adult Core Sets of health care quality measures to achieve "multi-level alignment."
- The feasibility for all health home programs to report a measure if Health Home Core Set reporting becomes mandatory in 2024.
- Measures that could be used to monitor quality of care for a new optional Medicaid health home benefit for children with medically complex conditions (known as Advancing Care for Exceptional Kids [ACE Kids] Health Homes). CMS is developing guidance about specific measures that ACE Kids Health Homes would be required to report and is seeking input from the Workgroup about potential measures to inform this guidance.

Before voting, Mathematica advised the Workgroup that there is no target number of measures—maximum or minimum—for the Home Health Core Set and that all measures would be reviewed and discussed in their specified form without conditions or modifications.

Summary of Workgroup Recommendations

The Workgroup recommended the removal of two measures from, and the addition of two measures to, the Health Home Core Set (Exhibit 6). This section summarizes the discussion and rationale for these recommendations. Please refer to Appendix C for information on the measures discussed but not recommended for removal from or addition to the Health Home Core Set. Measure information sheets about each measure the Workgroup considered are available on the Mathematica Health Home Core Set Review website.[19]

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2022 Health Home Core Set

Measure Name	Measure Steward	NQF #
Measures Recommended for Removal		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	NCQA	0004
Screening for Depression and Follow-Up Plan (CDF-HH)	CMS	0418*/0418e*
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Mental Illness	NCQA	3489
Colorectal Cancer Screening	NCQA	0034

* This measure is no longer endorsed by NQF.

CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

Measures Recommended for Removal

This section summarizes the Workgroup discussion of the two measures recommended for removal from the Health Home Core Set.

[19] The Measure Information Sheets for measures suggested for removal are available at https://www.mathematica.org/-/media/internet/features/2021/healthhomecoreset/hh-csr-measure-information-sheets_removals.pdf. The Measure Information Sheets for measures suggested for addition are available at https://www.mathematica.org/-/media/internet/features/2021/healthhomecoreset/hh-csr-measure-information-sheets_additions.pdf.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)

The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (IET-HH) measure assesses the percentage of health home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated AOD treatment and of those, the percentage who engaged in ongoing AOD treatment. Two rates are reported for this measure: (1) the percentage of enrollees who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis; and (2) the percentage of enrollees who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. The measure is stratified into four diagnosis cohorts: alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence, and total alcohol and other drug abuse or dependence. Twenty-seven of the 35 Medicaid health home SPAs that were expected to report IET-HH for FFY 2019 reported one or more rates included in the measure. The IET measure is also included in the Adult Core Set.

The Workgroup member who suggested IET-HH for removal indicated that health homes may not have access to the claims data required to track this measure. They suggested that the measure does not align with the strategic priority of the Medicaid health home program because health home programs are unable to directly influence performance on this measure, and that the measure is more applicable to providers. The Workgroup member suggested that two measures are appropriate replacements for this measure: *Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-HH), which is currently in the Health Home Core Set, and the *Follow-up after Emergency Department Visit for Mental Illness* (FUM), which was suggested for addition to the Health Home Core Set.[20]

During the discussion, several Workgroup members expressed concern about how the relatively small size of the health home population would impact reporting on the measure and measure results. A Workgroup member shared that it was difficult for rural states, in particular, to obtain large enough sample sizes for the separate AOD diagnosis cohorts included in the measure for the results to be meaningful. Another Workgroup member added that, even in a large state, the health home subpopulations can yield small denominators. A Workgroup member also commented that the small health home subpopulations made it difficult for the measure to be actionable and agreed with the replacement measures suggested by the Workgroup member who suggested IET-HH for removal.

During the public comment period, one commenter who works with a health home program expressed that while they believe IET-HH is an important measure, they found that the requirement of a primary diagnosis of substance use disorder (SUD) often leads to enrollees being missed since many of them have other primary behavioral health diagnoses. They said that

[20] The FUM measure was recommended by the Workgroup for addition to the Health Home Core Set. The Workgroup recommendation is discussed later in this report.

this led to performance on the measure not being representative of the interventions they offer to individuals with SUD.[21]

Screening for Depression and Follow-Up Plan (CDF-HH)

The *Screening for Depression and Follow-Up Plan* (CDF-HH) measure assesses the percentage of health home enrollees age 12 and older screened for depression using an age-appropriate standardized depression screening tool, and if the screen is positive, a follow-up plan is documented. Twelve of the 35 Medicaid health home SPAs that were expected to report CDF-HH for FFY 2019 reported the measure. The CDF measure is also included in the Child and Adult Core Sets.[22]

The Workgroup member who suggested the measure for removal indicated that states encounter challenges with provider coding of the information needed to calculate the measure from administrative claims (the measure uses G codes to document depression screens). The Workgroup member added that the measure has not been meaningful, as evidenced by the small number of states reporting the measure to CMS. The Workgroup member also indicated that removal of the CDF-HH measure would not leave a gap in the Health Home Core Set.

During Workgroup discussion, several Workgroup members spoke to the clinical importance and actionability of the measure as well as the prevalence of depression among health home enrollees; however, members differed in their opinions about whether the measure should be removed from the Health Home Core Set. One Workgroup member described the data for the measure as cumbersome and challenging to collect and questioned whether the measure is the best designed or if there might be an improved measure in the future.

Another Workgroup member inquired about whether the measure was no longer NQF endorsed because the measure steward had changed the measure significantly and that a newer version of the measure should be considered. In response, Mathematica said it was their understanding that the measure steward, CMS, did not seek renewal of the endorsement, and noted that NQF endorsement is not required for a measure to be included in the Health Home Core Set.

Another Workgroup member expanded on the challenges of reporting the CDF-HH measure, noting that the codes and claims used to report the measure are not always documented or routinely used, which can result in having to use greater resources to conduct chart review to determine whether there is a follow-up plan after a positive depression screen. Similarly, a Workgroup member noted that the measure is challenging because it is not based on a billable

[21] Public comments submitted on the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (IET-HH) measure can be found in Appendix D.

[22] For FFY 2020, the CDF measure was reported by 14 states for the Child Core Set and 15 states for the Adult Core Set. The measure does not meet the threshold for public reporting, which requires that a measure be reported by at least 25 states and meet CMS's standards for data quality. Among the reasons for not reporting are the lack of required codes in administrative claims/encounter data or the lack of electronic health records (EHRs) to calculate the measure. Note that the measure is not specified for the hybrid methodology using medical chart review.

encounter, and often requires a chart audit. Another Workgroup member confirmed these reporting challenges, indicating that their state has also been unable to calculate the measure for the Child and Adult Core Sets.

One Workgroup member suggested that technical assistance could be provided to help providers better code the measure. Another Workgroup member – reflecting on the tension between the desirability and feasibility of the measure – questioned whether working with providers to improve documentation on a claim would make this measure more accurate or if it would be better to add a different measure to the Health Home Core Set that would help assess how well states are doing with depression screening and follow-up.

A Workgroup member cautioned that removal of the CDF-HH measure, along with measures of ED visits and opioid use, which were also suggested for removal, could give the impression that these measures are not important for monitoring the Medicaid health home program. Instead, they suggested that the measures may not be contributing to demonstrating the impact of health homes in a way that can justify their importance in the Health Home Core Set. Another Workgroup member concurred that the impact of health homes cannot be accurately demonstrated if the data are not consistent and reflective of what is happening clinically across enrollees and programs.

In response, a Workgroup member noted that the *Follow-Up After Hospitalization for Mental Illness* (FUH-HH), *Use of Pharmacotherapy for Opioid Use Disorder* (OUD-HH), and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-HH) measures currently in the Health Home Core Set, along with other measures being suggested for addition, could allow states to demonstrate the impact of health homes.

During the public comment period, one commenter indicated that providers are documenting depression screening and follow-ups in EHRs. To improve reporting on this and similar measures, they suggested that states should improve their ability to leverage information from EHRs (in addition to administrative claims). Another commenter said the CDF measure underrepresents the depression screenings that are conducted in their state as the screens do not always occur during an outpatient visit (the measure denominator is the eligible population with an outpatient visit during the measurement year).[23]

Measures Recommended for Addition

This section summarizes the Workgroup discussion of the two measures recommended for addition to the Health Home Core Set.

[23] Public comments submitted on the *Screening for Depression and Follow-Up Plan* (CDF-HH) measure can be found in Appendix D.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Follow-Up After Emergency Department Visit for Mental Illness (FUM) measures the percentage of ED visits for beneficiaries age six and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported for this measure: (1) the percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit; and (2) the percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit. The measure is in the Adult Core Set for ages 18 and older and has been recommended for addition to the 2022 Child Core Set for ages 6 to 17.

Three Workgroup members suggested this measure for addition to the Health Home Core Set. They noted that high ED utilization is a challenge for Medicaid beneficiaries and that follow-up care for mental illness is associated with fewer subsequent ED visits. The Workgroup members cited the complex care needs of health home enrollees, particularly those with serious mental illness (SMI) and serious emotional disturbance (SED), and highlighted the need to coordinate and monitor care across delivery systems. One member indicated that FUM may be more relevant for health homes than *Ambulatory Care: Emergency Department (ED) Visits* (AMB-HH), which was suggested but not recommended for removal from the Health Home Core Set. The Workgroup member also suggested that health home programs stratify the measure by race and ethnicity.

During the discussion, several Workgroup members spoke to the feasibility and actionability of the measure as reasons to support its inclusion in the Health Home Core Set. For example, one Workgroup member noted that the 7-day and 30-day follow-up intervals made it more feasible for providers to follow up with health home enrollees in a timely manner. They also commented that allowing for any practitioner to conduct follow-up makes the measure more actionable. The Workgroup member noted that, for the purposes of alignment, this measure is included in the Adult Core Set, and was recommended for addition to the 2022 Child Core Set. Another Workgroup member agreed about the feasibility of reporting the measure and emphasized that the measure touches upon different elements of health homes, such as care coordination and relationship building.

Other Workgroup members shared concerns about adding FUM to the Health Home Core Set. One Workgroup member asked whether the denominator would be large enough for the measure to be meaningful for health homes. Mathematica noted that a Workgroup member who suggested this measure for addition indicated that the FUM measure has a larger denominator than the *Follow-Up After Hospitalization for Mental Illness* (FUH-HH) measure, which is currently included the Health Home Core Set and is reported by most SPAs, because generally there are more ED visits than hospital stays for mental illness. Another Workgroup member concurred that FUM had a slightly larger denominator than FUH in their state.

Another Workgroup member questioned the clinical relevance of calculating the measure given that it requires a principal diagnosis of a mental health disorder, but some health home enrollees will present to the ED with a non-mental health complaint, and the mental health diagnosis will be surfaced later. The measure steward explained that the measure denominator has a broad value set that includes a range of conditions, including SMI as well as other conditions. They added that in the numerator, the follow-up visits must include the mental health diagnosis, to ensure that the follow-up visit is targeted to the mental health component of the ED visit.

One Workgroup member said that they would prefer a measure of follow-up after ED visit for any condition, rather than one limited to mental illness as the principal diagnosis. In their experience, they found that most of their health home enrollees with mental health conditions present to the ED with a principal diagnosis unrelated to mental health. Another Workgroup member responded that they were not aware of any quality measures related to all-cause ED follow-up.

During the public comment period, one commenter anticipated that health homes would produce a low denominator for the measure.[24]

Colorectal Cancer Screening

Colorectal Cancer Screening measures the percentage of patients 50 to 75 years of age who had appropriate screening for colorectal cancer. The measure is specified for administrative, hybrid, and HEDIS ECDS data collection methods. The measure was recommended for addition to the 2022 Adult Core Set.

One Workgroup member suggested the measure for addition, as colorectal cancer represents the fourth leading cause of cancer cases and the second leading cause of cancer deaths in the United States. The Workgroup member also noted that the measure addresses specific prevention needs, and that as prevention may be neglected in individuals with chronic conditions, the addition of this measure would address that gap in care. The Workgroup member also cited data from California showing that rates of late-stage diagnosis of colorectal cancer among the Medicaid population were similar to the uninsured population and higher than the Medicare population. They also cited information that suggests racial and ethnic disparities among Medicaid enrollees.

Several Workgroup members expressed support for adding this measure to the Health Home Core Set. One Workgroup member noted that there was a straightforward way of reporting the measure from claims. Other Workgroup members commented that the measure was recommended for addition to the 2022 Adult Core Set, and there would be alignment by also adding the measure to the Health Home Core Set. Another Workgroup member indicated that the

[24] Public comments submitted on the *Follow-Up After Emergency Department Visit for Mental Illness* measure can be found in Appendix D.

measure would help support care coordination and whole-person care, one of the purposes of the Medicaid health home program.

Workgroup members also spoke to the value of the *Colorectal Cancer Screening* measure in reducing health disparities. One Workgroup member referenced the data about poor colorectal cancer screening rates among some racial and ethnic groups as well as higher risk for colorectal cancer. Another Workgroup member added that health homes should be monitoring health inequities within their populations and identifying services that enrollees need. Another Workgroup member acknowledged the potential difficulty with collecting data for the measure but supported adding the measure to the Health Home Core Set, in part because of its potential value in reducing health disparities.

Some Workgroup members expressed support for the measure but questioned whether health home care managers could impact its performance, and thus whether the measure was well suited for the Health Home Core Set. One Workgroup member suggested that care managers have an important role to play in providing education to members and reinforcing the importance of colorectal cancer screening. Another Workgroup member agreed that the health home was an ideal setting to drive improvement and enrollee outcomes on this measure, especially given the relationship building and trust that is developed in a health home environment.

Several Workgroup members raised challenges related to collecting the data needed to calculate the measure. One Workgroup member expressed support for the measure but also noted challenges obtaining Medicare data for measures with broad age ranges such as this one and requested technical assistance to help states better coordinate Medicare and Medicaid claims data for quality measurement. Another Workgroup member questioned whether CMS resources, including the State Data Resource Center, could assist states in reporting the measure. Some Workgroup members questioned the availability of data needed to calculate the measure, given the measure's 10-year look-back period. In particular, one Workgroup member noted that claims data will be incomplete for this population, and that the measure will ultimately be more reflective of data system capabilities rather than clinical performance until there are improvements in data interoperability. Another Workgroup member noted that, while they like the measure, they receive pushback from providers about calculating the measure from claims because of difficulty applying a10-year look-back period to the Medicaid population. Another Workgroup member acknowledged the data challenges, though continued to express support for the measure.

In response to a question from a Workgroup member, the measure steward said that while the measure is not currently specified for Medicaid, they are looking to add the Medicaid product line in the upcoming year. NCQA added that if the *Colorectal Cancer Screening* measure is adopted by CMS for the Adult and Health Home Core Sets, they could develop specifications for the 2022 Core Sets. NCQA also acknowledged the recommendation that screening begin at age 45 rather than age 50 and is considering expanding the age range for the measure.

Cross-Cutting Themes in Measure Discussions

Several cross-cutting themes emerged from the Workgroup's review of the three existing measures suggested for removal from the Health Home Core Set, the five new measures suggested for addition, and reflections about remaining gaps in the Health Home Core Set. The dominant themes related to the actionability of measures for health homes and the feasibility of reporting for states—and how to balance tradeoffs between the two criteria. The Workgroup engaged in thoughtful and insightful discussions about applying the framework for assessing health home measures (recall Exhibit 4) and the tensions inherent in balancing the desirability of a measure (which includes actionability and strategic priority) and its feasibility and viability (which includes data availability, consistency, and completeness as well as resource intensity).

This tension was notable during the deliberation of the *Colorectal Cancer Screening* measure, which the Workgroup recommended for addition to the Health Home Core Set. While several Workgroup members raised concerns about the 10-year look-back period required for the measure, as well as challenges obtaining data for health home enrollees dually eligible for Medicare and Medicaid, these concerns were generally outweighed by the potential for the measure to reduce racial and ethnic and insurance disparities in cancer screening and outcomes for Medicaid beneficiaries.

The tension between feasibility and actionability was highlighted during discussion of the *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) survey. Several Workgroup members acknowledged the importance of assessing beneficiaries' experience of care. However, several Workgroup members expressed concerns that health home programs may not be able to generate an adequate sample size and response rate to produce unbiased and reliable results. They also raised concerns about whether the CAHPS survey results would reflect experience in a health home versus other health care received. While the CAHPS survey was not recommended for addition to the Health Home Core Set, Workgroup members noted that lack of a measure of beneficiary experience is a remaining gap.

The interplay between the feasibility and actionability of measure results was a recurrent theme during discussion of removing the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)* measure from the Health Home Core Set. The Workgroup noted the importance of measures related to SUD treatment in the health home population and were concerned about the message they would be sending if this measure was recommended for removal. However, several Workgroup members noted that even states with larger health home populations had difficulty obtaining large enough sample sizes for stratification by the four diagnosis cohorts, which made it difficult for measure results to be actionable. Balancing these considerations, the Workgroup recommended removal of the measure from the Health Home Core Set.

The connection between feasibility and actionability also arose in the discussion of the *Follow-Up After Emergency Department Visit for Mental Illness* (FUM) suggested for addition and the

Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) measure suggested for removal. Both measures were considered feasible by Workgroup members because they are calculated using administrative claims data. The discussion focused on actionability by health homes, namely whether they could impact performance on the measure and ultimately use the measure to drive improvement in care. One Workgroup member believed the follow-up component of FUM made it a more actionable measure for a health home care manager than an all-cause ED visit measure like AMB-HH. Others noted that the AMB-HH measure provided a high-level indicator of the rate of ED visits in the enrollee population, which may be an indicator of the effectiveness of care management in avoiding ED visits overall. The Workgroup recommended addition of the FUM measure to the Health Home Core Set and did not recommend removal of the AMB-HH measure.

Finally, the discussions around removal of the *Screening for Clinical Depression and Follow-Up* (CDF-HH) measure and addition of the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure highlighted the trade-offs between the clinical importance of measures and considerations about data availability and data quality. Both measures were considered clinically important within the health home enrollee population, given the prevalence of depression and diabetes. For example, Workgroup members commented on the important role care managers can play in educating health home enrollees about controlling their HbA1c. However, both measures are challenging to calculate given lack of consistent and complete data across states. Workgroup members expressed concern about actionability of measure results that were driven largely by data quality and where variation across states was often a function of the data source and data completeness. The Workgroup recommended CDF-HH for removal from the Health Home Core Set and voted not to recommend addition of the HbA1c Poor Control measure for addition.

Discussion of Health Home Core Set Measure Gaps

During the 2022 Health Home Core Set Annual Review, the Workgroup discussed gaps in the Health Home Core Set. Mathematica asked the group to reflect on gaps that were raised during both days of the voting meeting, as well as measure concepts suggested for addition but not reviewed during the meeting (that is, housing status and oral evaluation).

Exhibit 7 synthesizes the gaps mentioned during the Workgroup discussions and public comment period. The exhibit does not attempt to prioritize the suggested gaps or assess their feasibility or fit for the Health Home Core Set.

Workgroup members had a robust discussion about the desirability and feasibility of including measures related to social determinants of health. They agreed there was a need to incorporate social determinants of health into the Health Home Core Set given the types of services that health homes provide, as well as the impact of social determinants of health on disparities and health care costs. The Workgroup acknowledged the challenges of collecting data related to social determinants of health and discussed ways in which these challenges could be mitigated.

For example, Workgroup members recommended incentivizing providers to report this information in administrative claims. In addition, they suggested gathering information from the assessments conducted by health home providers and linking to Access Monitoring Review Plans required by Medicaid. Workgroup members also suggested partnering with other entities, such as public health departments, to link data related to health home enrollees.

Many of the gaps Workgroup members identified reflected opportunities to improve measures recommended for removal from the Health Home Core Set but not replaced, as well as measures suggested but not recommended for removal or addition. For example, Workgroup members discussed opportunities to address Health Home Core Set gaps through measures of patient experience, dental and oral health care, depression screening and follow-up, and an all-cause ED follow-up measure. The Workgroup members also suggested exploring aspects of health care delivery via health homes (such as the referral process, care coordination, and care management), as well as opportunities to improve the consistency and completeness of data used to calculate Health Home Core Set measures.

The Workgroup's reflections about gaps in the Health Home Core Set provide a strong starting point for future discussions about updates to the Health Home Core Set, as well as longer-term planning for the Health Home Core Set.[25]

Exhibit 7. Synthesis of Workgroup Discussions About Potential Gaps in the Health Home Core Set

Themes from Cross-Cutting Gap Discussions
Measure Areas
• Social determinants of health, such as housing status • Patient experience of care • Depression screening and follow-up (more feasible than existing measure) • All-cause ED follow-up • Dental and oral health care, with a particular focus on children • Adverse childhood experiences (ACEs) • Trauma-informed care • Outcomes from assessments conducted by health home providers (for example, Patient Health Questionnaire-9 [PHQ-9], Differential Ability Scales-II [DAS] cognitive assessments, ACEs)
Health Care Delivery
• Progress and outcomes of referral process • Effectiveness of care coordination • Use of care managers within health homes
Other Measure Attributes
• Assessment of the sophistication of data systems and data completeness across states • Partnering with other entities, such as public health departments, to link data for health home members

[25] Public comments submitted on potential measurement gaps in the Health Home Core Set can be found in Appendix D.

Future Direction of the Medicaid Health Home Program

Mathematica solicited feedback from the Workgroup about the future direction of the Medicaid Health Home Core Set, as well as the new Advancing Care for Exceptional Kids (ACE Kids) Health Homes option for children with complex medical conditions. States implementing these health homes will be required to report quality measures, and these measures will be added to the Health Home Core Set in the future. Mathematica asked the Workgroup to suggest potential measures to monitor the performance of ACE Kids health homes. To facilitate the discussion, Mathematica provided a list of illustrative measures aligned with measures currently in the Child Core Set or recommended for addition.

The Workgroup discussion highlighted the following themes:

- **Care Coordination and Management.** Workgroup members highlighted the complex care needs of this population and stressed the importance of measures that help ensure that children's care is well coordinated and managed. For example, Workgroup members suggested measures related to medication management and appropriate follow-up for inpatient hospitalizations and ED visits. They also underscored the importance of assessing the management of a child's activities of daily living.
- **Preventive Services.** The Workgroup also suggested measures that focused on children's preventive services, such as dental services, immunizations, and well-child visits. They noted that preventive care can often be overlooked for children with complex medical conditions, and that there should be a balance between core preventive measures that every child should receive and measures that are more specific to the direct service needs of this population.
- **Care Transitions.** Workgroup members noted challenges related to care transitions for children with medically complex conditions—specifically challenges associated with transitions to adult care, as well as potential transitions into institutionalized care—and suggested that measures focus on transitions of care.
- **Other Considerations.** In addition to providing feedback on potential measures for ACE Kids Health Homes, the Workgroup surfaced other considerations when identifying measures for this population. As noted throughout discussions on the measures, they raised potential feasibility challenges associated with reporting measures for health home subpopulations, such as the ACE Kids population, due to small numbers. The Workgroup also encouraged CMS to engage providers and families in identifying appropriate measures for this population.

The Workgroup was also asked to comment on potential future directions for the Health Home Core Set. One Workgroup member suggested considering opportunities for improving alignment across other CMS care models and programs given the overlap in the populations each serves. They added that the complexity of reporting and the duplication of services may lead to challenges with reimbursement.

Additional Suggestions for Improving the Health Home Core Set and the Annual Review Process

In addition to recommending specific measures for removal from or addition to the Health Home Core Set, Workgroup members were asked to provide input about technical assistance (TA) opportunities to support reporting of the Health Home Core Set as well as suggestions for improving the Core Set Annual Review process.

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

The Workgroup provided several recommendations for TA to improve state reporting of Health Home Core Set measures. The opportunities focused primarily on providing TA to health home care teams, including tools that empower teams to improve performance on the measures. Specifically, the Workgroup encouraged providing decision support tools and TA to health home providers and care coordinators to better understand and improve performance on the Health Home Core Set measures. They discussed the roles and responsibilities of care managers and emphasized the importance of developing tools to help health home care teams assess their performance and identify opportunities for improvement. Another Workgroup member suggested providing information to help providers identify where there are gaps in care such as a detailed report on service receipt or complementary measures that can be used to target improvement activities.

Workgroup members also suggested providing quality improvement training and education to health home teams to encourage them to be more active participants in performance improvement. A Workgroup member also said that providing tools to providers about how they can better engage health home enrollees in their care may help with relationship building, which in turn may improve quality of care and advance health equity.

Additional recommendations included providing TA for Health Home Core Set measures that have been more difficult to for states to report, specifically *Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite,* as well as TA to support evaluating cost savings associated with health home programs, which is required by CMS as a condition of payment for health home programs separate from the Health Home Core Set measures.

Improving the Health Home Core Set Annual Review Process

In the spirit of continuous quality improvement, Workgroup members suggested enhancements to the Health Home Core Set Annual Review process. Workgroup members suggested potential improvements to the measure nomination and review processes. For example, one Workgroup member recommended that Mathematica indicate they are available to support Workgroup members during the call for measures process if they need help assessing whether suggested measures meet the criteria. Two Workgroup members suggested that the Workgroup discuss current gaps in the Health Home Core Set before reviewing measures suggested for removal or

addition. Understanding the gaps in the Health Home Core Set as well as reporting challenges earlier would provide additional context when considering measures, and better enable the Workgroup to view the measures as a "set" rather than as individual measures.

Workgroup members also suggested technology improvements to the Annual Health Home Core Set Review. Several members shared that while they appreciated receiving various resources Mathematica supplied to assist with the measure review process, it was difficult to access or navigate the file-sharing platform used to house these resources, and suggested Mathematica consider an alternate platform next year. Additionally, while several Workgroup members said they liked the voting platform, another member said that it was difficult to toggle between the separate platforms used for the Workgroup presentation and voting, and asked if it would be possible to streamline the technology.

Next Steps

The 2022 Health Home Core Set Annual Review Workgroup considered three measures for removal from the Core Sets and five measures for addition. Workgroup members recommended removing two measures and adding two measures to the Health Home Core Set for 2022. The Workgroup considered multiple factors when making their recommendations, 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.

During the discussion, Workgroup members frequently expressed a desire to select Health Home Core Set measures that could be used to monitor the complex care coordination and management needs of those enrolled in health home programs, especially as CMS looks ahead to the implementation of the new ACE Kids Health Homes. In addition, the Workgroup recommended increasing the focus on social determinants of health, such as housing status. Finally, Workgroup members focused on the importance of aligning the Health Home Core Set with state priorities and other state reporting efforts (including the Child and Adult Core Sets), analyzing and sharing Health Home Core Set results with health home providers to promote quality improvement, providing opportunities for technical assistance to improve reporting and performance on the measures, and acknowledging the challenges of using Health Home Core Set measures for quality improvement (particularly due to the diversity of enrollees across programs and small populations for inclusion in the quality measures).

The draft report was available for public comment from October 8, 2021 through November 5, 2021. Five public comments were submitted. These comments are included in Appendix D. CMCS will review the final report to inform decisions about whether and how to modify the 2022 Health Home Core Set. Additionally, CMCS will obtain stakeholder 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 2022 Health Home Core Set in early 2022.

Appendix A:
2021 Health Home Core Set Measures

Exhibit A.1. 2021 Core Set of Health Care Quality Measures for Medicaid Health Home Programs

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
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
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 is no longer endorsed by NQF.

AHRQ = Agency for Healthcare Research & 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

Appendix B:
Measures Suggested for Review at the 2022 Health Home Core Set Annual Review

Exhibit B.1. Measures Discussed at the 2022 Health Home Core Set Annual Review

Measure Name	Measure Steward	NQF #	Data Collection Method	Included in 2021 Child or Adult Core Sets
Measures suggested for removal				
Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	NCQA	NA	Administrative	Child Core Set Recommended for removal from the 2022 Child Core Set
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	NCQA	0004	Administrative or EHR	Adult Core Set
Screening for Depression and Follow-Up Plan (CDF-HH)	CMS	0418/0418e*	Administrative or EHR	Child and Adult Core Sets
Measures suggested for addition				
Follow-Up After Emergency Department Visit for Mental Illness	NCQA	3489	Administrative	Adult Core Set Recommended for addition to the 2022 Child Core Set
Asthma Medication Ratio	NCQA	1800	Administrative	Adult Core Set
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Administrative, hybrid, or EHR	Adult Core Set
Colorectal Cancer Screening	NCQA	0034	Administrative, hybrid, or ECDS	Recommended for addition to the 2022 Adult Core Set
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child and Adult Medicaid Versions	AHRQ**	0006	Survey	Child and Adult Core Sets

* This measure is no longer endorsed by NQF.

** AHRQ is the measure steward for the survey instrument in the Child and Adult Core Set and NCQA is the developer of the survey administration protocol.

Appendix C:
Summary of 2022 Health Home Core Set Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for removal from or addition to the 2022 Health Home Core Set. The discussion took place during the Workgroup meeting that was held on August 17 and August 18, 2021. The summary is organized by the order in which the measures were discussed. For more information about the measures discussed and not recommended for removal or addition, please refer to Exhibit C.1 at the end of this appendix. Exhibit C.1 includes the measure name, measure steward, National Quality Forum (NQF) number (if endorsed), measure description, data collection method, and key points of discussion about each measure.

Measure Discussed and not Recommended for Removal from the 2022 Health Home Core Set

Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)

The Workgroup discussed the *Ambulatory Care: Emergency Department (ED) Visits* (AMB-HH) measure, which was suggested but not recommended for removal from the Health Home Core Set. The measure is defined as the rate of ED visits per 1,000 enrollee months among health home enrollees. Two Workgroup members suggested this measure for removal, expressing concerns about the actionability of the measure. Both members noted that AMB-HH does not contribute to estimating the overall national quality of the Medicaid health home program, citing that some health homes may not have sufficient enrollment numbers to produce reliable results. They added that health homes may not have control over all populations going to the ED or the capability to analyze conditions driving ED use for the purpose of quality improvement. One Workgroup member commented that the AMB measure was recommended for removal from the 2022 Child Core Set, and noted that the measure steward is considering retiring the measure from their Medicaid line of business once there is a replacement measure.

During Workgroup discussion, members voiced concerns about leaving a gap in the Health Home Core Set if AMB-HH is removed. Two Workgroup members expressed interest in removing AMB-HH if a measure suggested as a replacement, *Follow-Up After Emergency Department Visit for Mental Illness* (FUM), was recommended for addition to the Health Home Core Set. Both members felt that FUM was more actionable for care managers but were concerned that recommending the removal of AMB-HH and not also recommending FUM for addition would result in a Health Home Core Set gap.

One Workgroup member also indicated that FUM, in addition to the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-HH) measure already in the Health Home Core Set, would be a better fit to measure the effectiveness of health home care management. One member commented that FUM is not an exact replacement for AMB-HH, since FUM strictly focuses on a behavioral or mental health visit whereas AMB-HH does not require a behavioral or mental health diagnosis.

The Workgroup had a robust conversation around the actionability of AMB-HH, with two Workgroup members noting that care managers should be able to educate their members on

appropriate ED use, involve them with crisis plans, and coordinate appropriate transitions of care. Another Workgroup member agreed with this perspective and offered that the AMB-HH measure is not specific enough to help health home teams understand whether the ED visit was avoidable. They added that ensuring proper follow-up after an ED visit was more actionable for care managers. Furthermore, they felt that the "per-one-thousand members" unit of analysis (which Mathematica clarified as "per one thousand enrollee months") was more members than most health homes could report on.

Another Workgroup member expressed support for the measure, noting that they analyze their ED data to identify high utilizers, opportunities for improvement, and progress in improving care. Another member agreed that the AMB-HH measure was a helpful tool for monitoring utilization but acknowledged the challenge of analyzing the conditions that drive ED use.

When discussing the potential for alignment with other Core Sets, a Workgroup member raised differences between the Child Core Set and Health Home Core Set measure technical specifications for this measure. They noted that the AMB-HH measure does not exclude behavioral health and chemical dependency services, and that these differences contradict the impression of full alignment.

In response to questions around the reasons for potential retirement of the measure and lack of NQF endorsement, the measure steward explained that it has never sought endorsement for AMB-HH due to the measure not being risk-adjusted. They added that unadjusted utilization measures, while useful, provide marginal information on quality and accountability, which is a requirement for NQF endorsement. NCQA said they are still considering the measure for retirement in the Medicaid line of business (it is retired in other lines of business), but they are not planning to retire it until there is a replacement measure. A Workgroup member expressed concern about the measure's lack of risk-adjustment, adding that without adjustment, the measure does not allow for proper comparison across populations.

Measures Discussed and not Recommended for Addition to the 2022 Health Home Core Set

Asthma Medication Ratio

Asthma Medication Ratio measures the percentage of beneficiaries ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The measure is included in both the Child and Adult Core Sets (AMR-CH and AMR-AD, respectively).

The Workgroup member who suggested this measure for addition indicated that asthma is prevalent among Medicaid beneficiaries and is a qualifying chronic condition for many health home programs. The Workgroup member also noted that the measure promotes effective care delivery and supports a goal of the Medicaid health home program, which is to improve health outcomes for beneficiaries with chronic conditions through care coordination. Citing data from

NCQA[26] and Child[27] and Adult[28] Core Set reporting, the Workgroup member indicated that there is room for improvement on the measure, and that health home programs and providers can directly influence improvement.

The Workgroup discussed challenges in reporting the measure, including (1) the measure's two-year measurement period when many health home enrollees are in health home programs a shorter duration, and (2) the lack of regularly available pharmacy data needed to calculate the measure. Two Workgroup members suggested the measure was confusing, with one Workgroup member asking why the measure description references persistent asthma but the technical specifications do not define how to determine this diagnosis. Workgroup members questioned whether the prevalence of asthma among the health home population was enough to make this a meaningful and actionable measure for the Health Home Core Set. In response, a Workgroup member noted that there is sufficient prevalence of asthma but suggested that if one of the goals of the measure is to reduce ED use due to uncontrolled asthma, whether it would be more actionable to monitor ED visits.

During public comment, one commenter noted that while asthma was very prevalent if the health home serves pediatric patients, access to pharmacy data to determine receipt of the asthma medication would be challenging for primary care providers.

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measures the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (>9.0%) during the measurement year. Two Workgroup members suggested this measure for addition to the Health Home Core Set, noting that the measure is currently in the Adult Core Set, and that state reporting of the measure shows evidence of substantial room for improvement. Additionally, they highlighted the importance of controlling diabetes across different health home programs as poor control is a risk factor for a number of health complications and can impact quality of life for health home enrollees. They noted that the health home care team can coordinate, schedule, and ensure HbA1c testing and follow-up to improve HbA1c results.

The Workgroup discussion on the measure reflected the tension between the desirability and feasibility of the measure. Workgroup members emphasized the clinical importance of controlling diabetes in the health home population but were concerned about whether health home care teams could effectively collect the data and directly influence outcomes. Several

[26] https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/.

[27] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-chart-pack.pdf.

[28] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

Workgroup members noted that health homes may have difficulty obtaining the data needed to calculate the measure from EHRs or electronic health information exchanges (HIEs) due to lack of interoperability. One Workgroup member expressed that until true interoperability is reached across providers and health homes, the measure assesses the quality of data systems rather than diabetes control. Another Workgroup member noted that many community-based organizations that manage health homes do not typically have access to laboratory results in the medical record or to an HIE, and even if they did, the care manager has little influence over a health home enrollee's diabetic control. Some Workgroup members disagreed, stating that health home care managers can encourage enrollees to take actions to control their HbA1c, and expressed support for the measure given the prevalence of diabetes among the health home population.

Workgroup members also shared their experiences with the measure technical specifications. In response to a question about the specificity of the optional frailty exclusion for individuals 66 and older in the specifications, Mathematica clarified that the measure technical specifications include value sets that are associated with specific codes for frailty. One Workgroup member commented that they use a similar measure to the one suggested for addition in the Health Home Core Set but look at a measure of poor control greater than 8 percent, rather than 9 percent. Another Workgroup member added that they were concerned about the 9 percent threshold, as it suggests that 8.5 or 8.9 percent is acceptable diabetes control and does not reflect patient-centeredness.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child and Adult Medicaid Versions

The CAHPS Survey provides information on the experiences of beneficiaries with their health care, or parents' experience with their child's health care. The CAHPS survey provides a general indication of how well the health care system meets beneficiaries' needs and expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates. Measures based on the CAHPS Health Plan Survey are currently included in the Child and Adult Core Sets. During discussion, the Child and Adult Medicaid versions of CAHPS were discussed together but voted on separately.

One Workgroup member suggested this measure for addition, noting that the measure would address a significant gap in the Health Home Core Set as there are currently no measures of enrollees' experience of care. While acknowledging the potential resource burden of the survey on states, the Workgroup member indicated that CAHPS would promote effective communication and patient engagement, which they described as vital for good health outcomes.

The Workgroup members spoke to the importance of measuring and monitoring experience of care but questioned whether CAHPS was the best tool to measure experience of care in the health home program. Several Workgroup members raised concerns about the ability to generate the sample size needed to survey a representative sample of health home enrollees, which was described as a very small subset of the Medicaid population. One Workgroup member raised the

potential burden to states of sampling for CAHPS, noting that the survey may be conducted by the state rather than well-resourced MCOs. Mathematica noted that the CAHPS measures could potentially be calculated at the program level rather than the SPA level (other Health Home Core Set measures are calculated at the SPA level), and that most states should have adequate enrollment to achieve 411 completed surveys using this methodology. One Workgroup member maintained that it would be difficult to yield sufficient sample size even at the health home program level. NCQA later clarified that only 100 responses are needed to calculate rates within the CAHPS measure.

Since some individuals may receive multiple CAHPS surveys, a Workgroup member also raised concerns about the general burden of CAHPS and questioned whether there is a better tool to evaluate experience of care. Some Workgroup members had used other patient experience surveys within their states and health home programs, with one member suggesting that the Workgroup consider what an ideal tool could look like for the health home population.

Several Workgroup members expressed concerns about CAHPS results in the context of the health home program. Citing 2019 California statewide Medicaid CAHPS data that had only a 17% response rate, a Workgroup member raised concerns about the potential for a low survey response rate from the relatively small health home population, and whether low response rates may introduce bias into the understanding of the survey results. Another Workgroup member also questioned the potential response bias of those who complete the survey, suggesting that only those who are dissatisfied with their care will respond, which will not provide representative information about who is and is not being well served by the health home. One Workgroup member raised concerns that the survey would not measure care coordination outside of a physician practice. Several Workgroup members questioned whether the survey results would reflect enrollee experience with the care received in a health home specifically as opposed to other care received.

A Workgroup member commented that there is a gap in the Health Home Core Set around measures of enrollee experience and care coordination and noted that CAHPS results can be used for quality improvement within health home programs. In response to comments raised by other Workgroup members, the Workgroup member indicated that there are opportunities to improve response rates through different modes of survey administration and technical assistance, the potential to yield an adequate sample using the program-level sampling methodology Mathematica mentioned, as well as analyses that can be done to understand potential survey bias. They also added that while CAHPS is not the only available tool, it may be the best tool available given the criteria Mathematica asked the Workgroup to consider.

During voting, neither CAHPS measure received support from the Workgroup for inclusion in the 2022 Health Home Core Set.[29]

[29] Public comments submitted on the *Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child and Adult Medicaid Versions* can be found in Appendix D.

Exhibit C.1. Measures Discussed by the 2022 Health Home Core Set Annual Review Workgroup and Not Recommended for Removal or Addition

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measure discussed and not recommended for removal from the 2022 Health Home Core Set			
Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) Measure steward: NCQA	Not endorsed	Rate of emergency department (ED) visits per 1,000 enrollee months among health home enrollees Data collection method: Administrative	• Suggested for removal due to concerns about actionability of an "all-cause" ED visit measure • Acknowledgement that the measure is not specific to a specific set of diagnoses, but allows health home programs to monitor ED utilization and identify opportunities for improvement • Concern that removing the measure without a replacement will leave a gap in the Health Home Core Set • Concerns that the measure is not risk-adjusted
Measures discussed and not recommended for addition to the 2022 Health Home Core Set			
Asthma Medication Ratio Measure steward: NCQA	1800	The percentage of beneficiaries ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year Data collection method: Administrative	• Suggested for addition due to the prevalence of asthma among Medicaid beneficiaries and because the measure helps promote care coordination • Concerns about the measure's two-year measurement period and availability of pharmacy data on medication receipt • Concerns that the prevalence of asthma among the health home population might be low in some health homes, which could make the measure challenging to report
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Measure steward: NCQA	0059	The percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%) during the measurement year Data collection method: Administrative, hybrid, or EHR	• Suggested for addition due to the prevalence and risk of diabetes among the health home population • Concern about the feasibility and actionability of the measure since many health homes are unable to collect the data due to lack of existing codes in administrative claims data and lack of access to EHR and HIE data • Concern about whether health home care managers are able to directly impact improvement on a clinical measure

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child and Adult Medicaid Versions Measure steward: AHRQ	0006	The CAHPS Survey provides information on the experiences of beneficiaries with their health care – or parents' experiences with their child's health care – and gives a general indication of how well the health care system meets beneficiaries' needs and expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates Data collection method: Survey	• Suggested for addition to address a gap in the Health Home Core Set around beneficiaries' experience of care • Suggested to promote effective communication and patient engagement • Concern about states' ability to generate sufficient sample size for the health home population given the number of health home program enrollees in many states • Concern about low survey response rates and the potential for response bias • Question about whether survey results would reflect experience specific to health homes versus other health care received by beneficiaries • Comment that CAHPS is the best available tool given the criteria for addition of measures to the Health Home Core Set • Discussion of need to explore other tools that could be used to measure experience among the health home population

Appendix D:
Public Comments on the Draft Report

The draft report was available for public review and comment from October 8, 2021 through November 5, 2021 at 8 p.m. Eastern Time, and stakeholders were invited to submit comments via email. Mathematica received a total of five public comments. Commenters included professional associations, stakeholder organizations, and individuals. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

Exhibit D.1 categorizes the public comments received on the draft report by the following topics: general comments, measures recommended for removal from or addition to the Health Home Core Set, measures considered but not recommended for removal or addition, and gap areas. Many comments addressed more than one topic, and commenters are listed under each applicable subject area. The verbatim public comments are included after the exhibit, organized in alphabetical order by commenter name (agency/organization or individual last name).

In summary, the majority of public comments were related to the two measures the Workgroup recommended for removal: *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (IET-HH) and *Screening for Depression and Follow-Up Plan* (CDF-HH). Comments were also received on one of the measures recommended for addition, *Follow-Up After Emergency Department Visit for Mental Illness*, and on one measure considered but not recommended by the Workgroup for addition, *Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child and Adult Medicaid Versions*.

Exhibit D.1. Summary of Public Comments by Topic and Commenter

Topic	Commenter
General Comments	• American Psychiatric Association • The American Association on Health and Disability (AADH) & The Lakeshore Foundation • Inseparable, The Kennedy Forum, Mental Health America, National Alliance on Mental Illness, National Association of Peer Supporters, and Wellbeing Trust
Measures Recommended for Removal from the 2022 Health Home Core Set	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	• American Psychiatric Association • The American Association on Health and Disability (AADH) & The Lakeshore Foundation • Harold Pincus, M.D. • Inseparable, The Kennedy Forum, Mental Health America, National Alliance on Mental Illness, National Association of Peer Supporters, and Wellbeing Trust • No Health Without Mental Health (NHMH)
Screening for Depression and Follow-Up Plan (CDF-HH)	• American Psychiatric Association • The American Association on Health and Disability (AADH) & The Lakeshore Foundation • Harold Pincus, M.D. • Inseparable, The Kennedy Forum, Mental Health America, National Alliance on Mental Illness, National Association of Peer Supporters, and Wellbeing Trust • No Health Without Mental Health (NHMH)
Measures Recommended for Addition to the 2022 Health Home Core Set	
Follow-Up After Emergency Department Visit for Mental Illness	• The American Association on Health and Disability (AADH) & The Lakeshore Foundation • Harold Pincus, M.D. • Inseparable, The Kennedy Forum, Mental Health America, National Alliance on Mental Illness, National Association of Peer Supporters, and Wellbeing Trust • No Health Without Mental Health (NHMH)
Measures Considered and Not Recommended for Addition to the 2022 Health Home Core Set	
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child and Adult Medicaid Versions	• The American Association on Health and Disability (AADH) & The Lakeshore Foundation • Inseparable, The Kennedy Forum, Mental Health America, National Alliance on Mental Illness, National Association of Peer Supporters, and Wellbeing Trust
Gap Areas	
Gap Areas	• The American Association on Health and Disability (AADH) & The Lakeshore Foundation • Harold Pincus, M.D.

Public Comments Listed Alphabetically by Agency/Organization Name or Individual Commenter's Last Name

American Psychiatric Association (Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych)

The American Psychiatric Association (APA), the national medical specialty society representing over 37,400 psychiatric physicians who treat mental health and substance use disorders (MH/SUD), would like to take the opportunity to comment on recommendations of the 2022 Medicaid Health Home Core Set Annual Review Stakeholder Workgroup. As you know, the integration of behavioral health and general medical services has been shown to improve patient outcomes, save money, and reduce stigma related to mental health. APA strongly supports CMS's efforts to support this model of integrated care through the Medicaid Health Home State Plan Option.

Quality measurement is a key tool in improving performance and demonstrating the value of programs such as the Medicaid Health Home option. We understand and appreciate the need to reduce the burdens associated with measurement initiatives, and to focus on the most high-priority, high-leverage measures; we also agree that the Medicaid Health Home Core Set should prioritize measures that meaningfully drive improvement in care delivery and health outcomes for Medicaid health home enrollees. However, APA is concerned about the removal of the following two behavioral health measures from the Core Set:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)
- Screening for Depression and Follow-Up Plan (CDF-HH)

While there is a clear need to balance competing priorities—including parsimony—in Core Sets, ensuring that depression and substance use disorders are managed optimally can be uniquely high-yield for improving quality and lowering costs. There remains a risk that if the Core Set does not directly address these components of care, important opportunities to improve value on a large scale will be missed. If the measures recommended for removal by the Core Set Workgroup are not feasible for implementation in the program or are not adequately reflecting quality of care in these areas, then APA would urge CMS to move quickly to identify or develop more appropriate measures that address these vital domains.

Thank you for the opportunity to comment. The APA welcomes the opportunity to further discuss any of our concerns and recommendations raised in this letter. Please contact Andrew Lyzenga, Deputy Director for Quality.

The American Association on Health and Disability (AADH) & The Lakeshore Foundation (Clarke Ross)

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments on this most important topic.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation, and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion, and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

Overview Comments

The statutory purpose of the Medicaid Health Home program is to "provide comprehensive care coordination for Medicaid beneficiaries with complex needs."

As CMS and its contract vendor Mathematica consider quality measurement and publicly accountable reportable performance measures, we strongly encourage constant consideration of the populations requiring coordination the most. These populations include:

1. Persons with co-occurring behavioral health and disability, including persons with co-occurring mental illness and ID-DD.
2. Persons with co-occurring behavioral health and chronic health conditions.
3. Persons dually eligible for Medicare and Medicaid.

We strongly encourage CMS and Mathematica to focus on linking and coordinating the Medicaid health home programs with other CMS sponsored programs serving persons dually eligible for Medicare and Medicaid, including the MMCO financial demonstrations for persons dually eligible for Medicare and Medicaid, PACE, D-SNPs, and Medicaid Managed Care Plans serving persons dually eligible. Many dually eligible persons have complex care needs, including chronic illness, physical disabilities, behavioral health issues, and cognitive impairments. They on average use more services and have higher per capita costs than those beneficiaries enrolled in Medicare or Medicaid alone. Many live with major social risk factors. A standalone Medicaid health home program, using different quality measures, just perpetuates the siloed programming that undermines the very purpose of the Medicaid health home program.

Regarding persons with co-occurring mental illness and ID-DD, we are happy and able to provide data from the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and its partner, Human Services Research Institute (HSRI).

Proposed Addition of the Measure – Follow-Up After Emergency Department Visit for Mental Illness

We fully support the addition by the project committee of this measure for 2022. Meaningful follow-up for all behavioral conditions following any hospitalization should be the larger goal, with post-emergency department visit quality measurements as a partial element for promoting whole person health.

Proposed Removal of Two Measures – Engagement for Alcohol and Other Drug Dependence; and Screening and Follow-Up for Depression

We join the October 30 submission by Harold Pincus, M.D., Columbia University Department of Psychiatry and member of many National Quality Forum committees; and the November 2 submission by Florence Fee, executive director, No Health without Mental Health (NHMH) – opposing the deletion of these measures. Dr. Pincus and Ms. Fee cite data on the impact of mental illnesses and alcohol and other drug dependence on the health of individuals, including those with complex needs (the purpose of the Medicaid home health program).

The purpose of the Medicaid health home program is the improvement of the health and wellness of persons with complex needs through coordinated services and supports. Excuses that providers are unable to document quality measures because of challenges with claims data and coding difficulties and supposed small sample sizes of persons with depression and alcohol and other drug dependence undermines the entire premise of health and wellness promotion for persons with complex needs.

Report's Concerns with Use of the CAHPS (Consumer Assessment of Healthcare Providers and Systems) Quality Instruments

Certain health professional criticisms, as not feasible, of the use of CAHPS is tiresome. CAHPS is a national approach developed and trademarked by the Agency for Healthcare Research and Quality (AHRQ) and widely used throughout the nation's health care system. What message does it send that the Mathematica committee states that CAHPS is not feasible?

Identification of Medicaid Health Home Quality Measurement Gaps

We fully support the recognition of Patient Experience of Care and Social Determinants of Health as major Medicaid health home quality measurement gaps. There are multiple experience of care instruments that could be used, or used with modification, in health homes. The objection of some health professionals to CAHPS reinforces the experience of care gap.

We respectfully remind Mathematica of the CMS “Meaningful Measures” goals and domains, which include: (1) prioritize outcome and patient reported measures; (2) chronic conditions; (3) seamless care coordination; (4) wellness and prevention; and (5) behavioral health. Removing behavioral health measures from the Medicaid health home measure set seems to undermine these CMS meaningful measures. We are happy that Social Determinants of Health are included in both the Mathematica committee recommendations and the CMS Meaningful Measures goals.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross.

Inseparable, The Kennedy Forum, Mental Health America, National Alliance on Mental Illness, National Association of Peer Supporters, and Wellbeing Trust (Mary Giliberti)

The undersigned groups collectively represent and advocate for millions of individuals with mental health and substance use conditions. We write to express strong concern that the overall recommendation adding one measure and removing two measures regarding mental health and substance use will decrease the emphasis on integrated care for all and quality care for people with serious mental illness in the health home program. While we support the additional measure of follow up after emergency mental health treatment, we are opposed to eliminating screening for depression and follow up care and engagement for alcohol and other drug dependence, given the high co-morbidities of the health home population. We urge a more robust measurement set that will support integrated care for those with co-morbid conditions and better care for those with serious mental illness.

We want to underscore the comments of No Health Without Mental Health and join their deep concern that:

> The committee has in effect, by its action recommending 2 BH measures be removed and one be added, failed to strengthen quality measures for individuals with serious mental illness (SMI), and for individuals with behavioral health co-morbidities. The former represent the largest number of health home SPAs by target population, and the latter a large proportion of the broader population of health home participants.

We also strongly support the use of patient experience data, such as the Consumer Assessment of Healthcare Providers and Systems (CAPHS). As organizations that serve and include many individuals with lived experience, the experience of care is a critical element in an overall quality measurement set. CAPHS has been tested and used widely by many providers. The current recommendations fail to adequately capture patient experience.

For the removal of the quality measures and the recommendation against the use of CAPHS, provider burden is cited. However, depression and follow up is a measure of the Medicaid core sets for both children (ages 12-17) and adults and is also a measure required of FQHCs and ACOs. If this measure is included in all of these measure sets and those providers can report this data, it is hard to understand why heath homes cannot also do so.

The overall recommendations give great deference to provider burden while giving less weight to patient needs for high quality care and positive experiences. Any removal of quality measures should be accompanied by better and stronger measures of integration and quality behavioral healthcare. This is particularly important given that COVID has exacerbated mental health and substance use conditions. Accordingly, we urge that the additional measure be added, the removals be rejected and we strongly recommend further consultation with Dr. Harold Pincus and other experts on mental health quality measurement to ensure greater commitment to integration and improved care for individuals with mental illness.

No Health Without Mental Health (NHMH) (Florence Fee)

NHMH - No Health without Mental Health, www.nhmh.org, a 501(c)(3) patient advocacy nonprofit, with a focused mission to make effective behavioral health (BH) care services widely available in medical settings, and physical care in specialty BH settings, submits the following comments on the above-referenced matter:

NHMH is deeply concerned that the committee has in effect, by its action recommending 2 BH measures be removed and one be added, failed to strengthen quality measures for individuals with serious mental illness (SMI), and for individuals with behavioral health co-morbidities. The former represent the largest number of health home SPAs by target population, and the latter a large proportion of the broader population of health home participants.

This action by the committee has in effect narrowed the focus of quality accountability for these high priority populations.

This at a time when the entire healthcare policy community is focused on ways to deliver high quality, efficient care to these populations.

And bearing in mind that patients with behavioral and medical chronic conditions co-morbidity represent THE most costly patient group in our healthcare system, absorbing 80% of total health system expenditures (Milliman, 2018). Treating behavioral conditions alongside chronic medical conditions of these patients must be the health system's top goal. Especially among the Medicare and Medicaid beneficiary populations, where multi-morbidity is the norm.

If we are to move healthcare providers to higher quality, more efficient, valued-based care delivery models, quality measures upon which practitioners can be evaluated and reimbursed, must be uppermost. Yet the committee has taken action that narrows, not broadens, the focus of quality accountability for these high-need, high-cost, priority populations.

We urge the committee to redouble its efforts to develop more, and meaningful, quality measures that address improved care quality at the interface of behavioral health and general health care.

Harold Pincus, M.D., New York State Psychiatric Institute at Columbia University

My comments relate to the failure of the committee to strengthen measures for individuals with serious mental illnesses (SMI), the largest number of Health Home SPAs by target population, and for individuals with behavioral health comorbidities (representing a large proportion of the broader population of Health Home participants). The committee recommended that two measures related to behavioral health be removed and one be added. The end result is that the focus of quality accountability for these high priority populations has been narrowed. My colleagues and I have published numerous peer reviewed papers in notable journals that focus on the interface of behavioral health and general health care. Several of those (listed below) discuss and suggest quality measures at this interface. I would recommend that the committee consider some of the strategies and suggestions for potential measures noted in these publications.

Quality Indicators for Physical and Behavioral Health Care Integration. Goldman ML, Spaeth-Rublee B, Pincus HA.JAMA. 2015 Aug 25;314(8):769-70. doi: 10.1001/jama.2015.6447.PMID: 26043185 Free PMC article.

Quality Measures at the Interface of Behavioral Health and Primary Care. Goldman ML, Spaeth-Rublee B, Nowels AD, Ramanuj PP, Pincus HA.Curr Psychiatry Rep. 2016 Apr;18(4):39. doi: 10.1007/s11920-016-0671-8. PMID: 26898821 Free PMC article.

Prioritizing quality measure concepts at the interface of behavioral and physical healthcare. Pincus HA, Li M, Scharf DM, Spaeth-Rublee B, Goldman ML, Ramanuj PP, Ferenchick EK. Int J Qual Health Care. 2017 Aug 1;29(4):557-563. doi: 10.1093/intqhc/mzx071.PMID: 28651345 Free PMC article.

The Case for Severe Mental Illness as a Disparities Category. Goldman ML, Spaeth-Rublee B, Pincus HA. Psychiatr Serv. 2018 Jun 1;69(6):726-728. doi: 10.1176/appi.ps.201700138. Epub 2018 Feb 15.PMID: 29446331 Free PMC article.

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