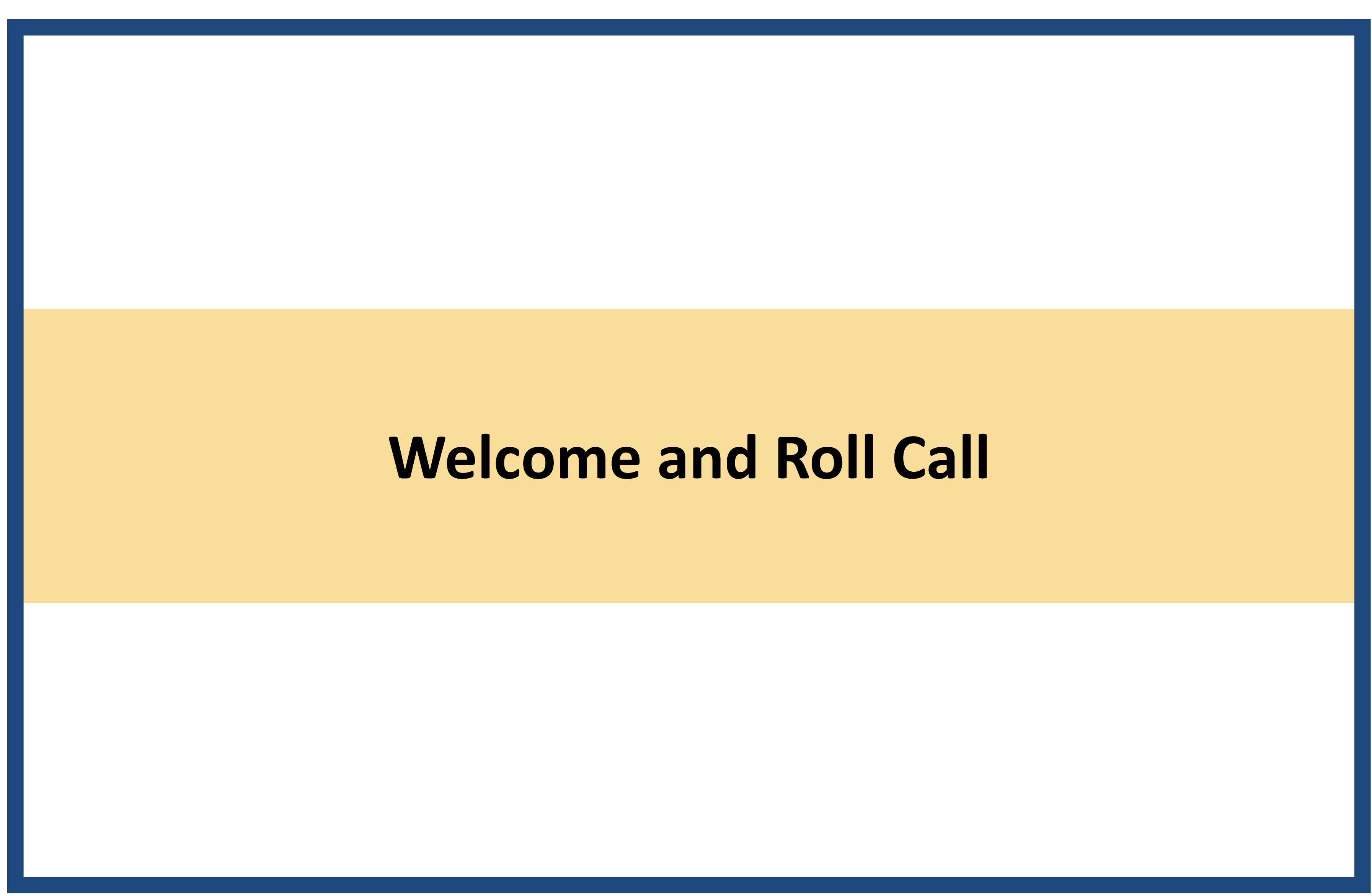
Tailored Care Management Technical Advisory Group (TAG)

Meeting #4: Quality Measures

January 28, 2022

Agenda

- **Welcome and Roll Call (5 mins)**
- **Key Updates (5 mins)**
- **Quality Measures (35 mins)**
  - Level-Setting
  - Tailored Care Management Quality Measures Deep Dive
  - Discussion
- **Public Comments (10 mins)**
- **Next Steps (5 mins)**


Welcome and Roll Call

Department of Health and Human Services

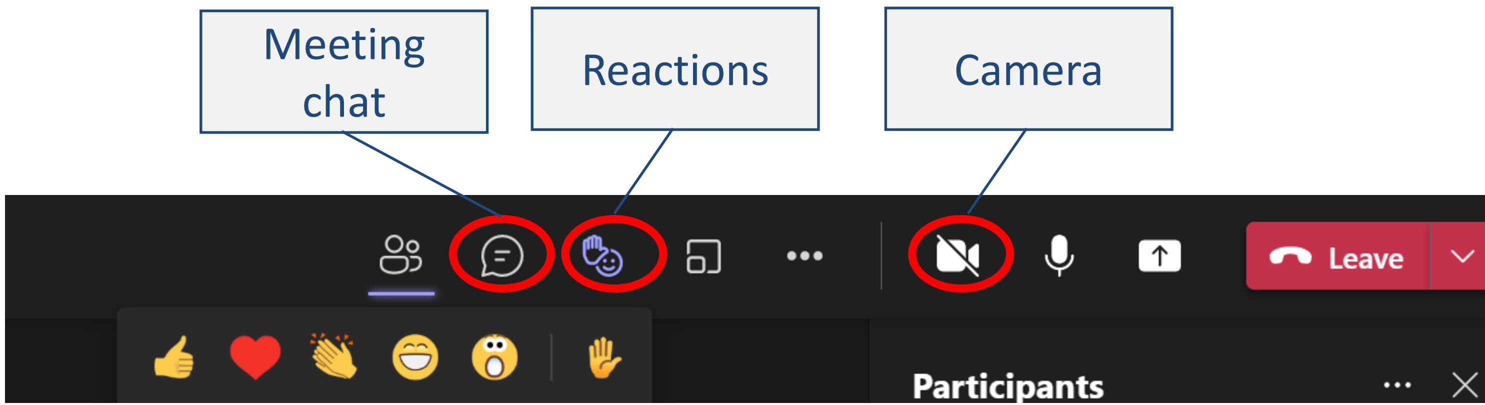
Kelly Crosbie, MSW, LCSW	Krystal M. Hilton, MPH	Gwendolyn Sherrod, MBA, MHA	Keith McCoy, MD	Eumeka Dudley, BS
Chief Quality Officer NC Medicaid, Quality and Population Health	Associate Director of Population Health, NC Medicaid, Quality and Population Health	Senior Program Manager for Population Health, NC Medicaid, Quality and Population Health	Deputy CMO for Behavioral Health and IDD Community Systems, Chief Medical Office for Behavioral Health and IDD	Tailored Care Management Program Manager, NC Medicaid, Quality and Population Health

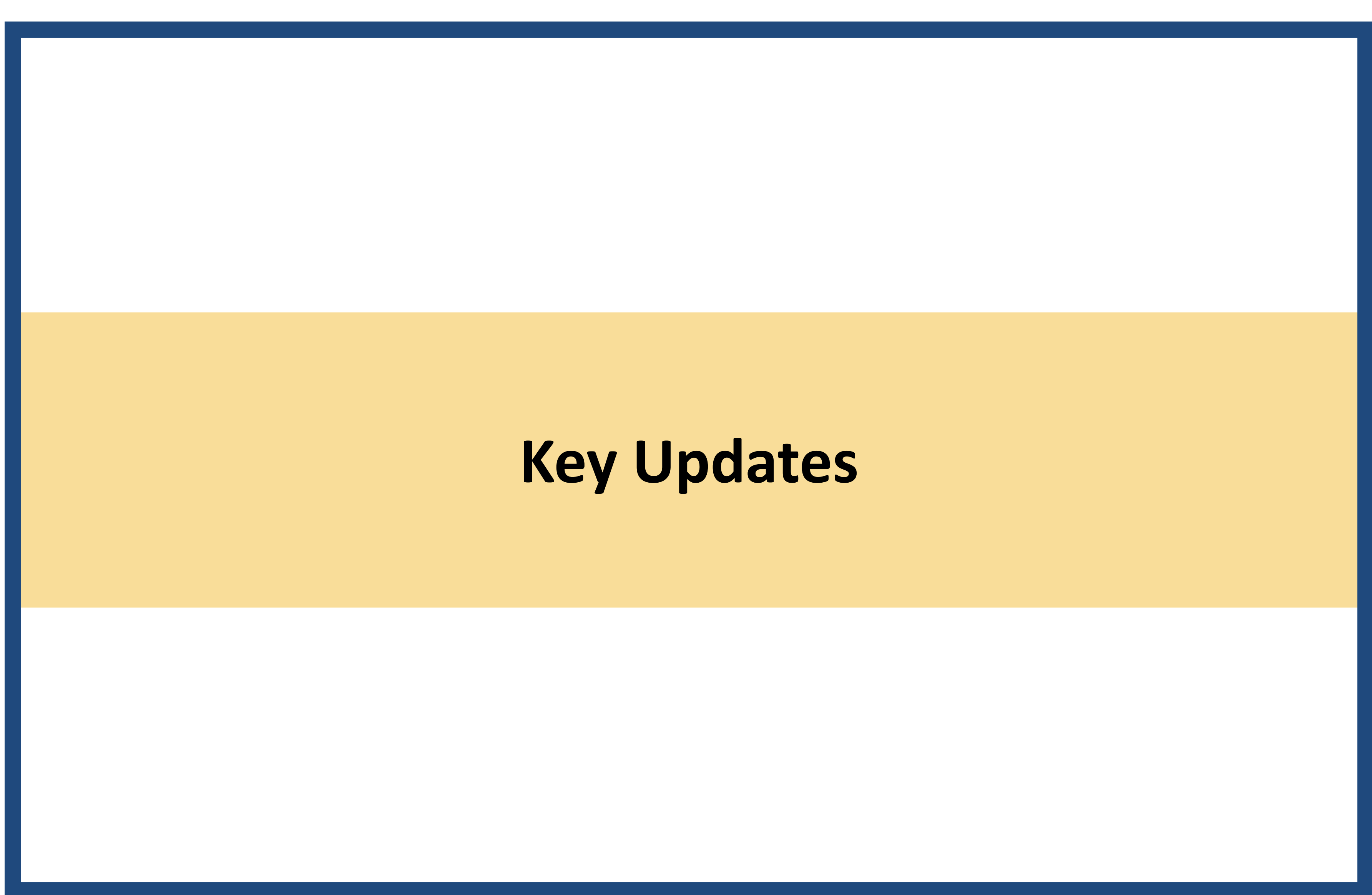
Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Lauren Clark	Coastal Horizons Center	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Jason Foltz, D.O.	ECU Physicians	Provider Representative
Natasha Holley	Integrated Family Services, PLLC	Provider Representative
DeVault Clevenger	Pinnacle Family Services	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
John Gilmore, M.D.	UNC Center for Excellence in Community Mental Health	Provider Representative
Sean Schreiber	Alliance Health	Tailored Plan Awardee
Josh Walker	Eastpointe	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Sabrina Russell	Sandhills Center	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Rhonda Cox	Vaya Health	Tailored Plan Awardee
Cindy Lambert	Cherokee Indian Hospital Authority	Tribal Option Representative
Jessica Aguilar	N/A	Consumer Representative
Pamela Corbett	N/A	Consumer Representative
Alicia Jones	N/A	Consumer Representative
Cheryl Powell	N/A	Consumer Representative

Increasing Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.




Key Updates

Key Updates (1/3)

The Department recently released the following resources.

***Updated* Tailored Care Management Provider Manual**

***New* Guidance on Care Manager Extenders**

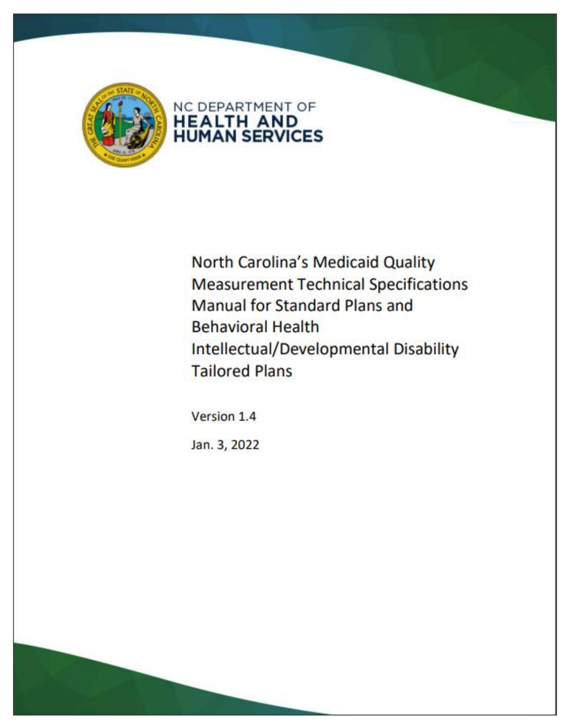
***Updated* Tailored Care Management Rates**

***New* Frequently Asked Questions (FAQ) Resource from Tailored Care Management Webinar Series**

Resources are available on the Tailored Care Management webpage: https://medicaid.ncdhhs.gov/transformation/tailored-care-management

Key Updates (2/3)

The Department also released the 2022 Quality Measurement Technical Specifications Manual in early January.


North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans

Version 1.4

Jan. 3, 2022

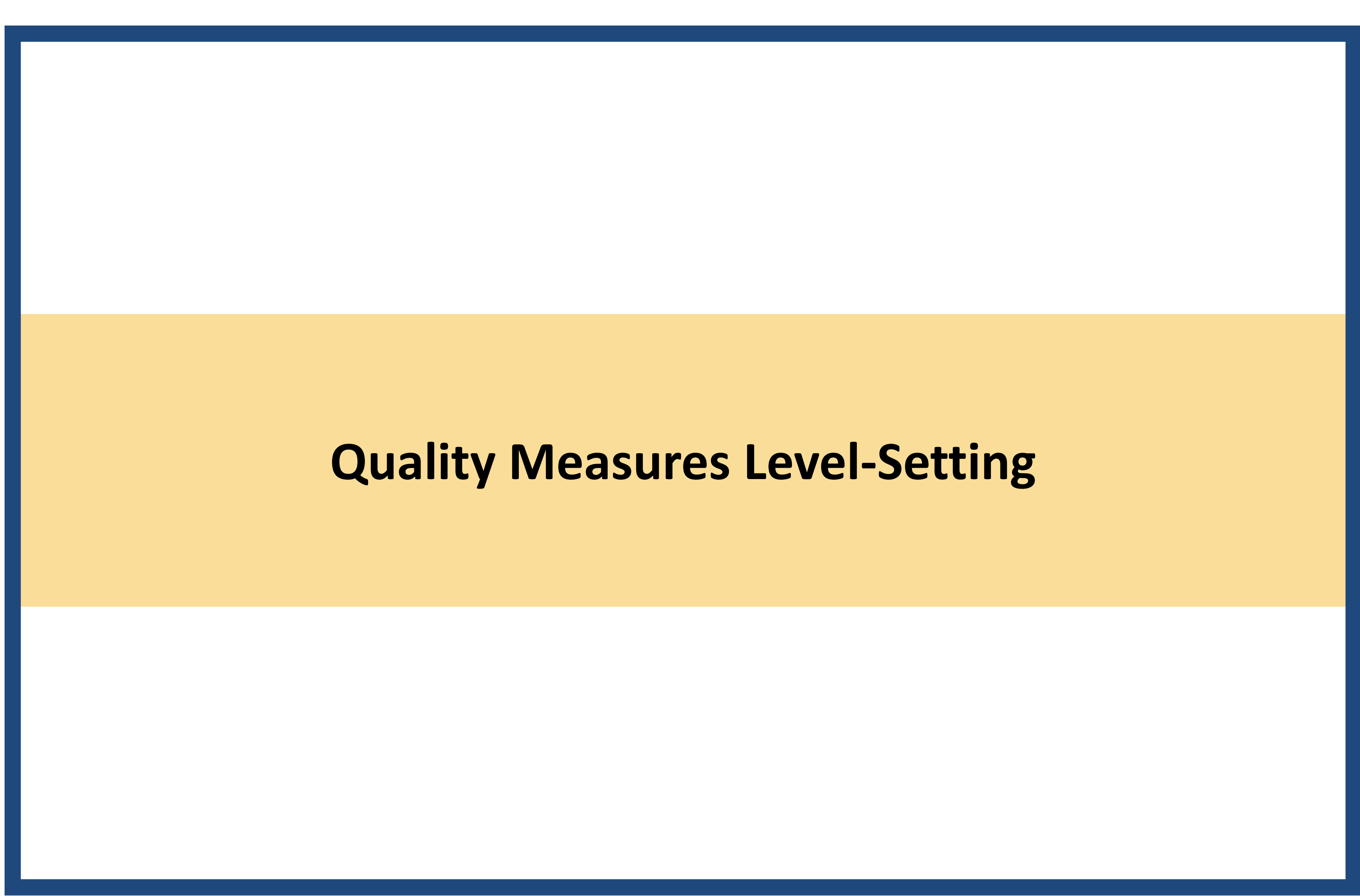
The Technical Specifications are posted on the Quality Management and Improvement page: https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

Key Updates (3/3)

The Department will pause the launch of the Tailored Care Management TAG Data Subcommittee and instead introduce a new provider forum offering technical assistance on Tailored Care Management data and system requirements.

- In November 2021, the Department began planning for the **launch of a Tailored Care Management TAG Data Subcommittee** that would convene stakeholders to:
  - Increase understanding of core Tailored Care Management data, system, and reporting requirements, needs, and concerns; and
  - Advise on potential solutions to address concerns.
- Earlier this month, the Department identified a **new urgent need** to provide Tailored Care Management providers with a forum to receive technical assistance around Tailored Care Management data and system requirements.
- As a result, the Department has decided to:
  - **Pause launch of the Tailored Care Management TAG Data Subcommittee** until a later date; and
  - **Establish a new forum to offer technical assistance** for providers on Tailored Care Management data and system requirements.

For Discussion: **What types of implementation support would be most useful or effective for Tailored Care Management providers?**


Quality Measures Level-Setting

Objectives for Today's Discussion

- Based on the Quality Strategy*, the Department has developed a Medicaid quality management program that includes reporting, analysis and evaluation of quality measures and performance at various levels (e.g., Department, Medicaid Managed Care Plans, providers, external quality reviewer).
- Today's conversation is focused on **reviewing the Tailored Plan quality framework** and **discussing proposed quality measures** for an AMH+/CMA improvement program.

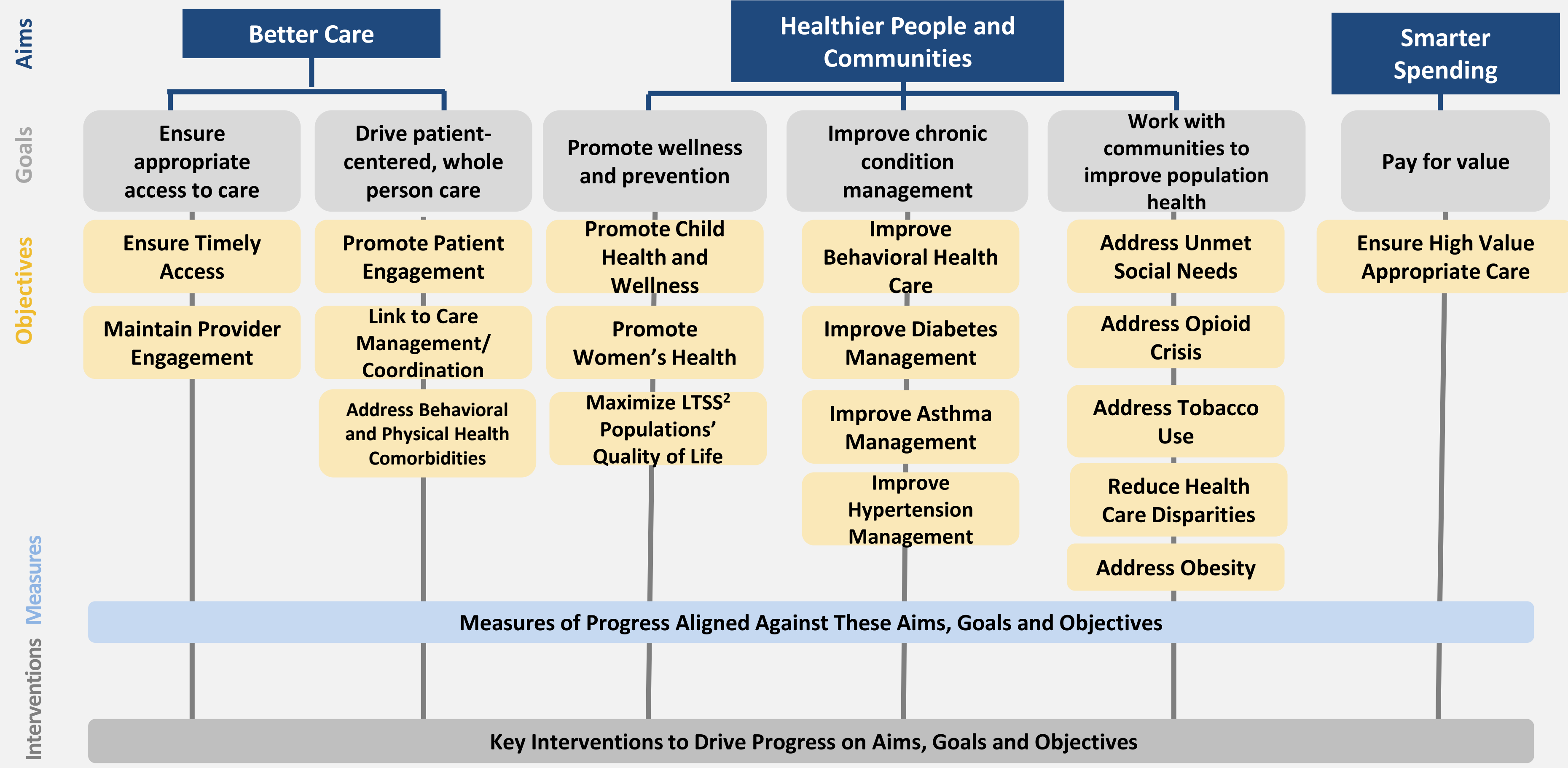
*The Department's Quality Strategy can be found at: https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

Key Definitions

Term	Definition
Quality Measure	Standards for measuring whether providers and health plans deliver care at the right time to patients.
Healthcare Effectiveness Data and Information Set (HEDIS)	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of quality measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). More information can be found here.
Medicaid and CHIP Child and Adult Core Sets	Developed by the Centers for Medicare and Medicaid Services (CMS), the Core Sets are a set of quality measures that assess access to—and quality of—the health care Medicaid and CHIP beneficiaries receive. States are required to report these measures to CMS. More information can be found here.
Health Information Exchange Authority (HIEA)	A secure electronic network that gives authorized health care providers the ability to see and share patient information across a statewide information network. Providers may use the HIEA to learn whether a patient has had a recommended vaccine or test or to share information with other providers. More information about North Carolina's HIEA, NC HealthConnex, can be found here.
Health Home	The Affordable Care Act (ACA) of 2010 created an optional program for states to establish so-called "Health Homes" to coordinate care for people with Medicaid who have chronic conditions. A Health Home can be a managed care organization or a provider practice. More information can be found here.
Advanced Medical Home (AMH)	The AMH program is the primary vehicle for delivering care management as the state transitions to Medicaid managed care. The AMH program requires Standard Plans to delegate certain care management functions to AMHs at the local level.
ADT Alert	Electronic notification for a member's care team to indicate a change in the member's health status (e.g., inpatient hospitalization).

Department's Quality Vision Applies to All Medicaid Members

The NC Medicaid Quality Strategy[1] defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in North Carolina. The strategy is comprised of three aims, with multiple underlying goals and objectives.



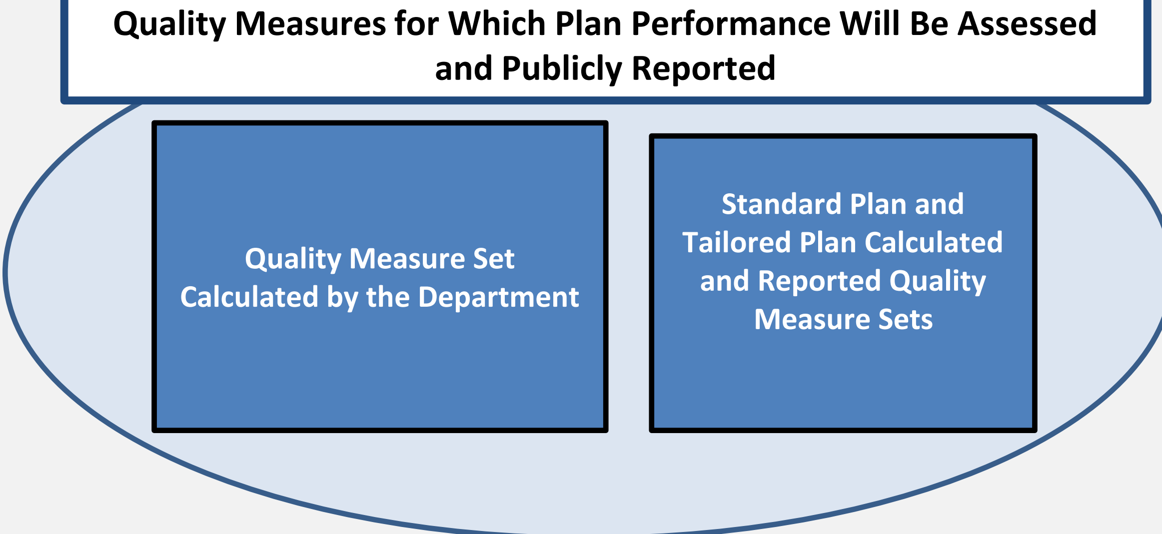
1. The Department's Quality Strategy can be found at: https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement
2. LTSS = Long-Term Services and Supports

Tailored Plan Quality Measures are Standardized

- To ensure that all NC Medicaid Managed Care beneficiaries receive high-quality care, Tailored Plans will be expected to report on, and ultimately be held accountable for, performance against measures aligned to a range of specific goals and objectives used to drive quality improvement and operational excellence.
- The Tailored Plan measures reflect the Department's commitment to reporting measures aligned with the HEDIS and Adult/Child Core sets. The measures also reflect Tailored Care Management and Health Home requirements (see Appendix).
- Consistent with the Department's desire to benchmark its progress against other states' performance and assess key priorities to drive continuous quality improvement efforts, nearly all measures are nationally recognized.
- The Department will update quality measure sets and performance benchmarks annually to reflect the:
  - Evolution of measure sets and technical specifications; and
  - Discontinuity in performance reporting as providers transition to managed care.

Quality and Administrative Reporting Responsibilities Differ By Measure

- Most measures will be measured and calculated directly by the Department via claims submitted by Tailored Plans and clinical data from the HIEA (see Appendix).
- Tailored Plans will also collect, calculate and report quality measures to the Department (see Appendix).



Tailored Care Management Quality Measures Deep Dive

The Department will Release Standardized Measures for AMH+ Practices/CMAs

- For Standard Plans contracting with Advanced Medical Home (AMH) practices, the Department has established a specific subset of measures Standard Plans can use in their contracts with Advanced Medical Homes. This set can be found in the Technical Specifications* (link below).
- The Department has **not** yet established an analogous set of measures for Tailored Plans contracting with AMH+ practices/CMAs.
- The Department is considering a small set of measures for future use to inform Tailored Care Management practice improvement.
- ***These measures address areas that can be affected by care management (see next slide).***

*The Technical Specifications can be found here: https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

Proposed AMH+/CMA Practice Improvement Measures

The AMH+/CMA set measures were considered based on applicability for the Tailored Plan population and to reflect the influence of the care manager and other team members.

These measures were identified based on whether they 1) aligned with other DHHS quality measure sets (e.g., AMH set); 2) aligned with the Quality Strategy aims, goals and objectives; and 3) can be measured at the practice level.

NQF#	Measure Name	Measure Descriptions	Steward	Tailored Plan Performance CY 2020
N/A	Child and Adolescent Well-Care Visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit during the measurement year	NCQA	48%
0576	Follow-up After Hospitalization for Mental Illness (7-Day/30-Day)	The percentage of discharges for patients six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.	NCQA	7-Day: 28% 30-Day: 47%
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of patients 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	78%

The following slides illustrate how the care manager and other team members may impact improvement for these three measures.

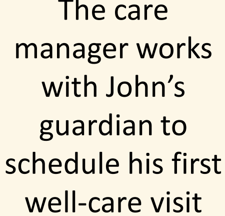
Example 1: Child and Adolescent Well-Care Visits

John turns 3 years old in March and is eligible for his well-care visit.

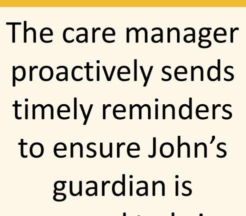
February

March-April

The care manager* engages with John's guardian to share the importance and benefits of continuing well-child visits and help develop lists of questions or concerns for providers to address



The care manager works with John's guardian to schedule his first well-care visit



The care manager proactively sends timely reminders to ensure John's guardian is prepared to bring John to his visit

The care manager identifies that John's guardian needs transportation support to get to John's appointment. The care manager arranges for a taxi on the day of the appointment

The care manager follows up with John's guardian to confirm they attended the assigned visit, gets feedback, reviews follow-up plans and helps schedule the next appointment (as needed)

John attends visit; his care has met quality measure standards

*Or other team members

Example 2: Follow-up After Hospitalization for Mental Illness

Theresa, 31 years old, is hospitalized for psychosis in February. Theresa's care manager is notified of the admission and visits her at the hospital.

Day 0

The care manager* receives an ADT alert that Theresa has been admitted to the hospital. The care manager engages with Theresa's inpatient team to support discharge planning

Days 1 and 2

The care manager works with Theresa to change how she organizes and stores her medications in her home to prevent another unplanned readmission to the hospital

The care manager engages with Theresa to develop a list of questions or concerns for her mental health provider

Day 6

The care manager attends the follow-up visit with Theresa

Theresa attends visit; her care has met quality measure standards

*Or other team members

Example 3: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Bob, 56 years old, is living with Bipolar Disorder. John's care manager identifies that he is eligible for and has not yet received a diabetes screening from his primary care provider (PCP).

January

The care manager*, as part of a quarterly scan, identifies that Bob is a Tailored Plan member with Bipolar Disorder on an antipsychotic medication who has not yet received a diabetes screening

February

The care manager contacts Bob to confirm whether he has a primary care provider (PCP) and discuss the importance of getting screened for diabetes

The care manager helps Bob find and set an appointment with a PCP and arranges an appointment to collect a blood sample for his diabetes screening

Bob attends visit; his care has met quality measure standards

March

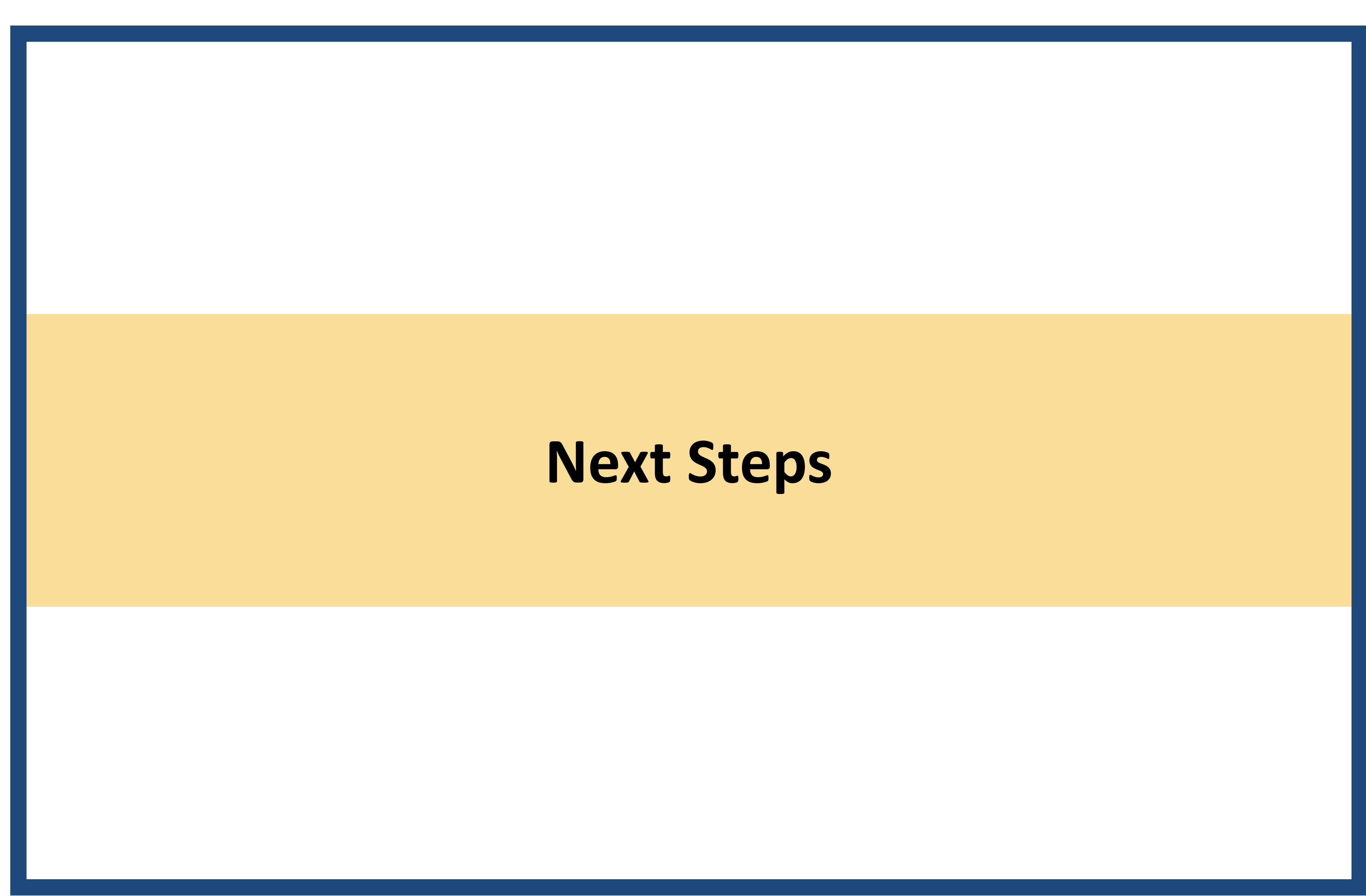
Following Bob's positive screening for diabetes, the Care Manager engages John to discuss diabetes management with his PCP and helps enroll him in a lifestyle program to manage his condition

*Or other team members

Discussion

1. Do Tailored Care Management TAG members think the proposed quality measures will drive improvement in these key areas (i.e., well-care visits, post-hospitalization follow-up, diabetes screening)?
2. Are there additional areas that should be considered for inclusion in the quality framework? How can these areas best be measured at the practice level?
3. Other feedback?

Public Comments


Next Steps

Next Steps

Tailored Care Management TAG Members

- Share today's discussion key takeaways with your networks

Department

- Discuss feedback received during today's Tailored Care Management TAG meeting
- Prepare for February 25th Tailored Care Management TAG session

Tailored Care Management TAG Meeting Cadence

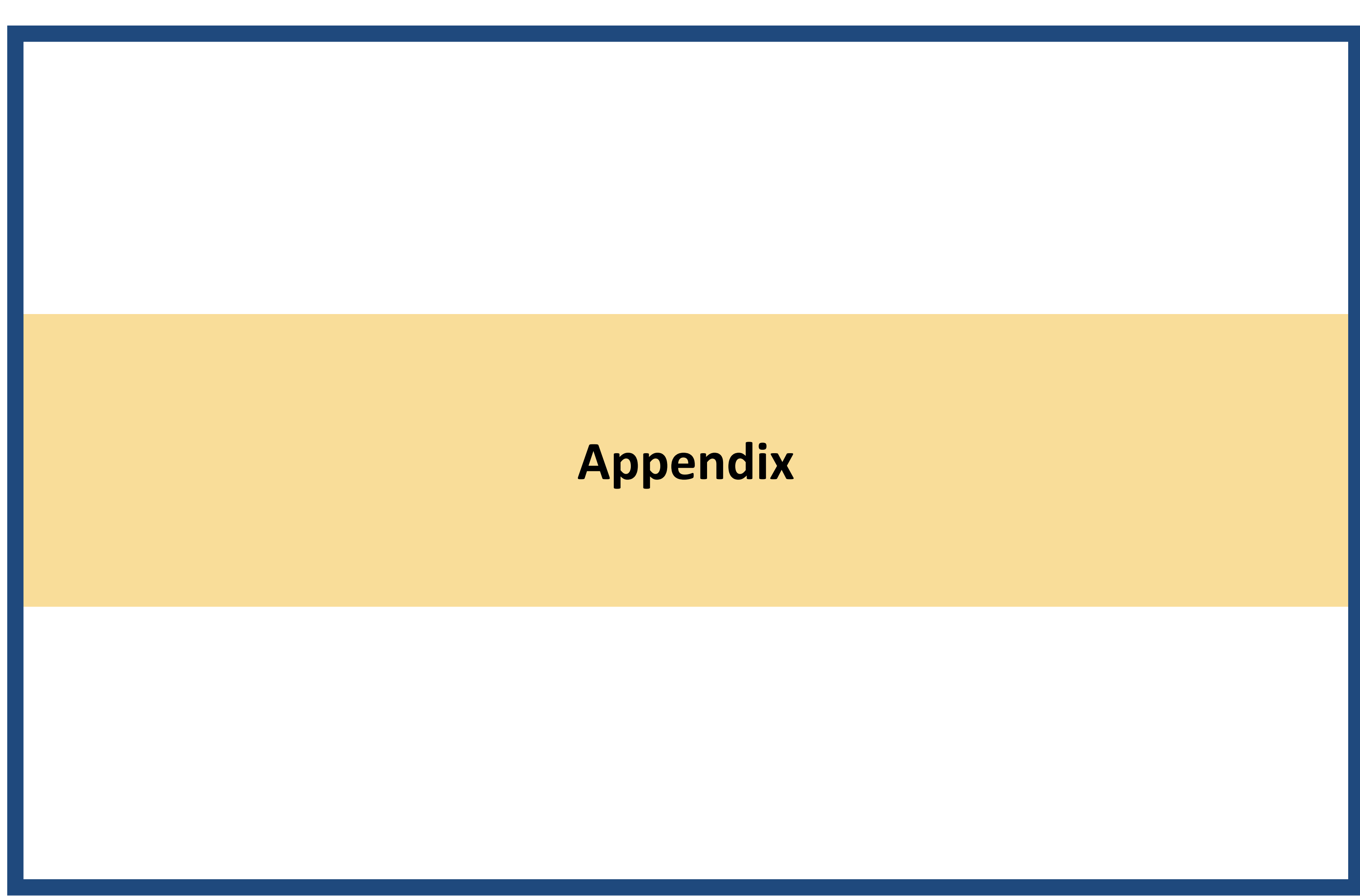
Tailored Care Management TAG meetings will generally take place the last Friday of every month from 3:30-4:30 pm ET.

2022 Meetings:

February 25, March 25, April 22, May 27, June 24, July 22, August 26, September 23

Previous Meetings:

- **Meeting #1:** Friday, October 29, 3:00 – 4:30 pm ET (presentation, minutes)
- **Meeting #2:** Friday, November 19, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #3:** Friday, December 17th, 3:30 – 4:30 pm ET (presentation, minutes)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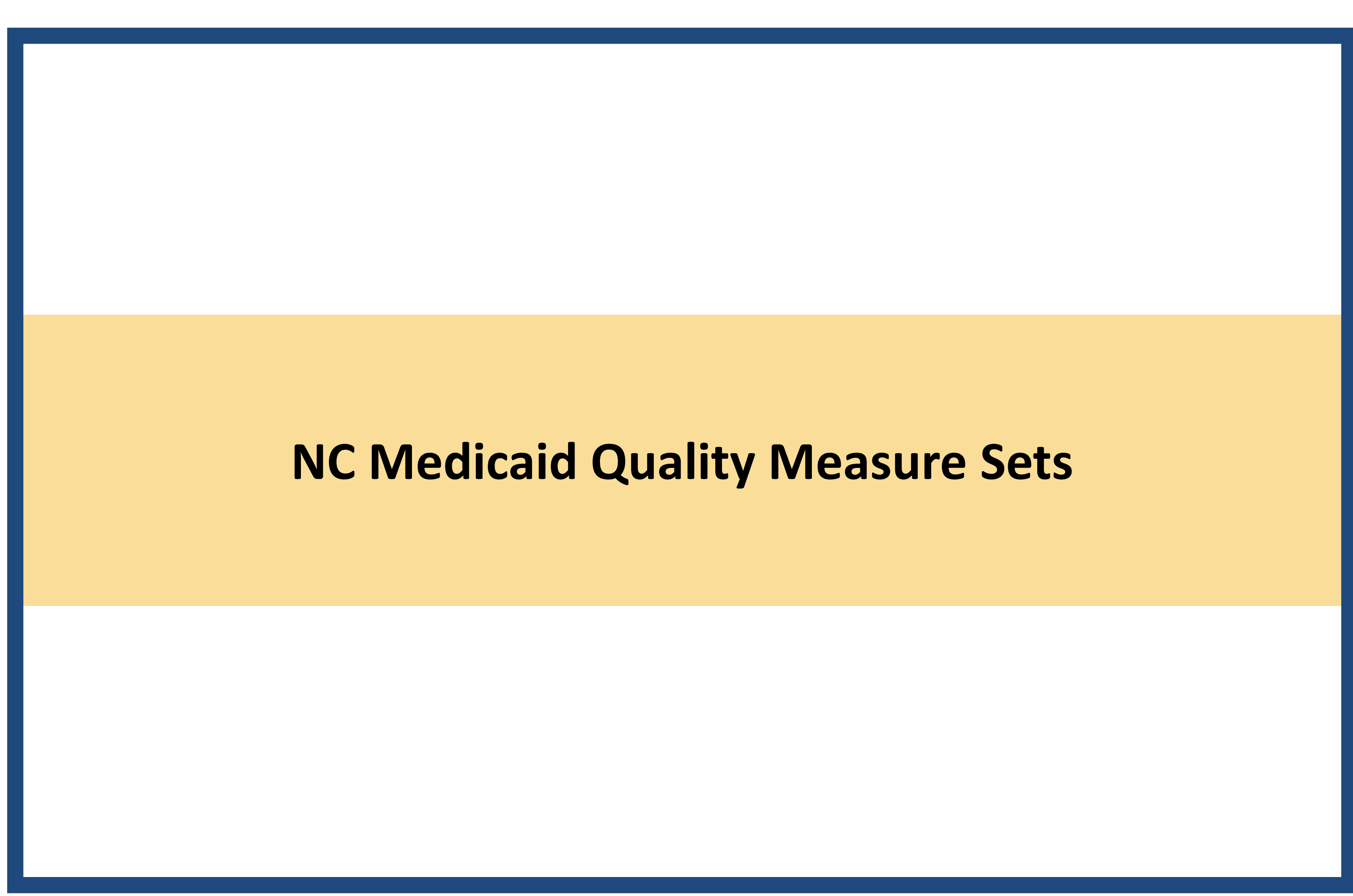

NC Medicaid Quality Measure Sets

Tailored Plan Quality Measure Set (1 of 2)

Plans will be responsible for reporting the following measures:

NQF #	Measure Name	Steward
Pediatric Measures		
NA	Child and Adolescent Well-care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combo 10) (CIS)	NCQA
0108	Follow-up for Children Prescribed ADHD Medication (ADD)	NCQA
1407	Immunization for Adolescents (Combo 2) (IMA)	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
NA	Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	NC DHHS
2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
NA	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0105	Antidepressant Medication Management (AMM)	NCQA
0032	Cervical Cancer Screening (CCS)	NCQA
0033	Chlamydia Screening in Women (CHL)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC
0018	Controlling High Blood Pressure (CBP)	NCQA
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD, SMD, SMC)	NCQA

Notes: Innovations and TBI measures are also included in the Tailored Plan measure set.
Standard Plans and Behavioral Health I/DD Tailored Plans are required to provide gap reports for selected measures to AMHs and AMH+/CMAs, respectively.

Tailored Plan Quality Measure Set (2 of 2)

Plans will be responsible for reporting the following measures:

NQF #	Measure Name	Steward
Adult Measures		
0039	Flu Vaccinations for Adults (FVA, FVO)	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	NCQA
1768	Plan All-cause Readmissions (PCR)	NCQA
NA	Rate of Screening for Unmet Resource Needs	NC DHHS
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF)	NCQA
NA	Total Cost of Care	TBD
2940	Use of Opioids at High Dosage in-Persons Without Cancer (OHD)	PQA
2950	Use of Opioids from Multiple Providers in-Persons Without Cancer (OMP)	PQA
Maternal Health Measures		
NA	Low Birth Weight	NC DHHS
NA	Prenatal and Postpartum Care (PPC)	NCQA
NA	Rate of Screening for Pregnancy Risk	NC DHHS

Notes: Innovations and TBI measures are also included in the Tailored Plan measure set.
Standard Plans and Behavioral Health I/DD Tailored Plans are required to provide gap reports for selected measures to AMHs and AMH+/CMAs, respectively.
The Department will work jointly with plans to calculate and report the low birth weight measure.

Department-Calculated Measure Set (1 of 3)

The Department will calculate and monitor the following quality measures in the Medicaid program but may report these measures at the plan-level.

NQF #	Measure Name	Steward
Pediatric Measures		
N/A	Avoidable Pediatric Utilization PDI 14: Asthma Admission Rate PDI 15: Diabetes Short-term Complications Admission Rate PDI 16: Gastroenteritis Admission Rate PDI 18: Urinary Tract Infection Admission Rate	Agency for Healthcare Research and Quality (AHRQ)
0004	Initiation/Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA
NA	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	CMS
2803	Tobacco Use and Help with Quitting Among Adolescents	NCQA
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCQA
Adult Measures		
N/A	*Planned for 2022:* Ambulatory Care: Emergency Department (ED) Visits (AMB)	NCQA
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA
0543	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	CMS
N/A	*Planned for 2022:* Admission to an Institution from the Community (AIF)	CMS
0023	Adult BMI Assessment (ABA)	NYC Dept. of Health and Mental Hygiene
1800	Asthma Medication Ratio (AMR)	NCQA
NA	Avoidable Adult Utilization PQI 01: Diabetes Short-term Complication Admission Rate; PQI 05: COPD or Asthma in Older Adults Admission Rate; PQI 08: Heart Failure Admission Rate; PQI 15: Asthma in Younger Adults Admission Rate	AHRQ
2372	Breast Cancer Screening (BSC)	NCQA
0061	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	NCQA
0575	Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (<8.0%)	NCQA
0057	Comprehensive Diabetes Care (CDC): HbA1c Testing	NCQA
0064	Comprehensive Diabetes Care (CDC): LDL-C Control (<100 mg/dL)	NCQA
0063	Comprehensive Diabetes Care (CDC): LDL-C Screening	NCQA

Department-Calculated Measure Set (2 of 3)

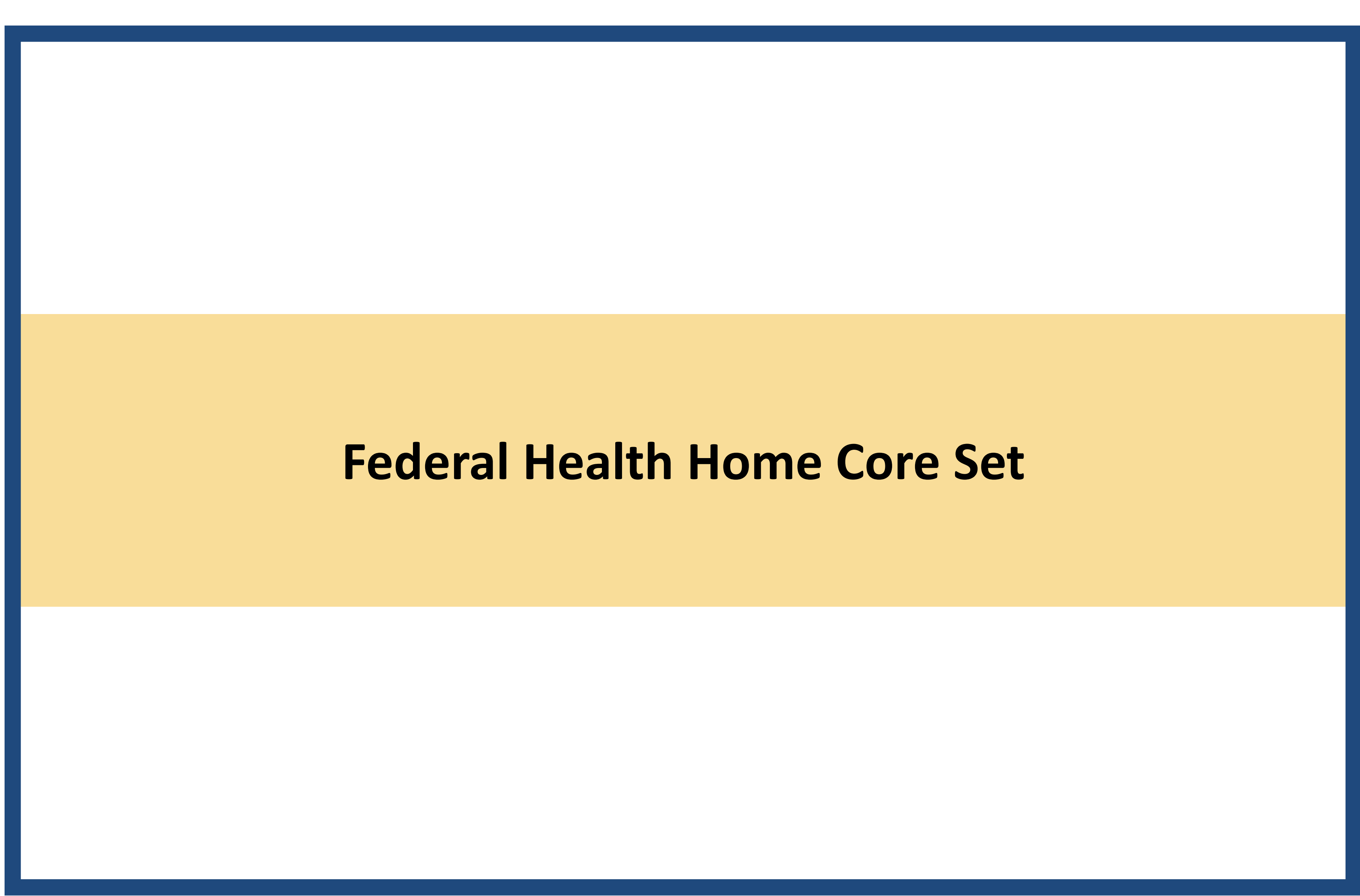
The Department will calculate and monitor the following quality measures in the Medicaid program but may report these measures at the plan-level.

NQF #	Measure Name	Steward
Adult Measures		
0547	Diabetes and Medication Possession Ratio for Statin Therapy	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)	NCQA
3488	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	NCQA
3489	*Planned for 2022:* Ambulatory Care: Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA
3210/32 10e	HIV Viral Load Suppression (HVL)	HRSA
N/A	*Planned for 2022:* Inpatient Utilization (IU)	CMS
2856	Pharmacotherapy Management of COPD Exacerbation (PCE)	NCQA
0028	Preventive Care and Screening; Tobacco Use: Screening and Cessation Intervention	PCPI Foundation
N/A	*Planned for 2022:* Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI 92)	AHRQ
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
3400	*Planned for 2022:* Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS

Department-Calculated Measure Set (3 of 3)

The Department will calculate and monitor the following quality measures in the Medicaid program but may report these measures at the plan-level.

NQF #	Measure Name	Steward
Maternal Health Measures		
2904	Contraceptive Care: Access to Long-acting Reversible Contraception (LARC) (CCW)	US Office of Population Affairs
2903	Contraceptive Care: Most and Moderately Effective Methods (CCW)	US Office of Population Affairs
2902	Contraceptive Care: Postpartum (CCP)	US Office of Population Affairs
1382	Live Births Weighing Less Than 2500 Grams	CDC
NA	Prenatal Depression Screening and Follow-up (PND)	NCQA
Select Public Health Measures		
NA	Diet/Exercise o Increase fruit and vegetable consumption among adults o Increase percentage of adults who get recommended amount of physical activity Opioid Use o Reduce the unintentional poisoning mortality rate Tobacco Use o Decrease the percentage of adults who are current smokers o Decrease the percentage of high school students using tobacco o Decrease the percentage of women who smoke during pregnancy o Decrease exposure to secondhand smoke in the workplace	NA
Patient Satisfaction		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
NA	Provider Survey	DHHS


Federal Health Home Core Set

Federal Health Home Core Set

Measure Name	Steward/NQF #	Description	Numerator	Denominator	Data Source	Entity Responsible for Reporting
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	NCQA/NQF #004	Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment • Engagement of AOD Treatment	• Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. • Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	Members age 13 years of age and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the intake period of January 1-November 15 of the measurement year.	Administrative or EHR	Tailored Plan in collaboration with providers sharing clinical data, as needed.

Federal Health Home Core Set

Measure Name	Steward/NQF #	Description	Numerator	Denominator	Data Source	Entity Responsible for Reporting
Controlling High Blood Pressure (CBP)	NCQA/NQF #0018	Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).	The number of beneficiaries in the denominator whose most recent blood pressure (both systolic and diastolic) is adequately controlled during the measurement year.	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year.	Administrative, hybrid, or EHR	Tailored Plan in collaboration with providers sharing clinical data, as needed.
Screening for Depression and Follow-Up Plan (CDF)	NCQA/NQF #0418/0418e	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	Patients screened for clinical depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.	All patients aged 12 years and older.	Administrative or EHR	

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

Federal Health Home Core Set

Measure Name	Steward/NQF #	Description	Numerator	Denominator	Data Source	Entity Responsible for Reporting
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA/NQF #0567	The percentage of discharges for enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.	• 30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. • 7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.	Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.	Administrative	Tailored Plan
Plan All-Cause Readmissions (PCR)	NCQA/NQF #1768	For members 18-64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.	Members ages 18-64 as of the Index Discharge Date with an acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year.	Administrative	Tailored Plan

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

Federal Health Home Core Set

Measure Name	Steward/ NQF #	Description	Numerator	Denominator	Data Source	Entity Responsible for Reporting
Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS/NQF #3400	Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	Adults in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.	Adults aged 18 years and older who had a qualifying encounter during the performance year, and a diagnosis of OUD and pharmacotherapy for OUD during the denominator identification period.	Administrative	The Department
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	NCQA/NQF #3488	Assesses emergency department visits for members 13 years of age and older with a principal diagnosis AOD or dependence, who had a follow up visit for AOD.	• 30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). • 7-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days).	Adults aged 18 and older as of the ED visit.	Administrative	
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92)	AHRQ/NQF Not Available	Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions.	Discharges for patients age 18 and older who meet the criteria for any of the following Prevention Quality Indicators: PQI 01, PQI 03, PQI 05, PQI 07-08, PQI 14-16	Total number of months of enrollment for beneficiaries age 18 and older during the measurement period.	Administrative	

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

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Measure Name	Steward/NQF #	Description	Numerator	Denominator	Data Source	Entity Responsible for Reporting
Admission to an Institution from the Community (AIF)	CMS/NQF Not Available	The number of MLTSS enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term (1 to 20 days), medium-term (21 to 100 days), or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.	Number of admissions to an institution (nursing facility or ICF/IID) during the measurement year per 1,000 enrollee months for MLTSS beneficiaries 18 and older.	Number of enrollee months for MLTSS beneficiaries age 18 and older.	Administrative	The Department
Ambulatory Care: Emergency Department (ED) Visits (AMB)	NCQA/NQF Not Available	Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19.	Number of ED visits (non-duplicative).	Number of beneficiary months.	Administrative	
Inpatient Utilization (IU)	CMS/NQF Not Available	Rate of acute inpatient care services (total, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months.	Inpatient stays and length of stay.	Eligible population.	Administrative	

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