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Medicaid Health Home Core Set Stakeholder Workgroup:

Measure Suggested for Addition to the 2023 Health Home Core Set

Measure Information Sheet
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MEASURE INFORMATION SHEET

HEALTH HOME CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions**
Description	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Meaningful Measures area(s)	Promote Effective Prevention & Treatment of Chronic Disease
Measure type	Process
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	No

Technical Specifications	
Ages	Age 18 years and older as of the ED visit. The measure contains two age stratifications and a total rate: • Ages 18 to 64. • Age 65 and older. • Total (age 18 and older).
Data collection method	Administrative (claims only).
Denominator	An ED visit on or between January 1 and December 24 of the measurement year where the member was 18 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all ED visits between January 1 and December 24 of the measurement year. Eligible ED visits are identified where the member had two or more different chronic conditions prior to the ED visit. Eligible chronic condition diagnoses are as follows (each bullet indicates an eligible chronic condition): • COPD and asthma • Alzheimer's disease and related disorders • Chronic kidney disease • Depression • Heart failure • Acute myocardial infarction • Atrial fibrillation • Stroke and transient ischemic attack

Numerator	A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for a follow-up visit: • An outpatient visit • A telephone visit • Transitional care management services • Case management visits • Complex care management services • An outpatient or telehealth behavioral health visit • An intensive outpatient encounter or partial hospitalization • A community mental health center visit • Electroconvulsive therapy • A telehealth visit • An observation visit • A substance use disorder service • An e-visit or virtual check-in
Exclusions	Exclude members with any of the following: • ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. • In hospice or using hospice services any time during the Measurement Period.
Continuous enrollment period	365 days prior to the ED visit through 7 days after the ED visit. No more than one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.
Level of reporting for which specifications were developed	Plan-level.
Health home focus area	Chronic conditions.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The measure is currently specified for Medicare only. According to the Workgroup member (WGM) who suggested the measure for addition, two states (Virginia and Georgia) considered using this measure in their state quality strategy but ultimately elected not to use the measure because of its designation as a Medicare population measure.

Description of required data source and data elements, including any barriers, limitations, or variations that could affect consistency of calculations	The WGM indicated that the measure requires administrative claims and encounters using standard HEDIS code sets.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality in Medicaid health home programs	The WGM noted that this measure contributes to measuring the overall quality of health home programs because many health home programs enroll individuals with multiple chronic conditions. Health home programs are also required to provide comprehensive care management and coordinators who should be able to follow-up after an ED visit to ensure that enrollees receive appropriate follow-up services.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The HEDIS MY 2022 specifications include general guidance on how plans may stratify measures by race and ethnicity. Race and ethnicity stratification of this measure is currently voluntary within HEDIS. Note that NCQA requires plans that stratify by race and ethnicity to report the data using the categories defined by the Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM noted that health home enrollees with multiple chronic conditions are at risk of ED visits. Through the health home model, care managers are uniquely positioned to follow-up after an ED visit, ensure care needs are addressed, and reduce further use of the ED among members with multiple chronic conditions at risk of ED visits.
Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	The WGM noted that published performance results of this measure have focused on the Medicare population.[1] In 2018, NCQA reported the Medicare managed care rate was 54.8 percent. In 2020, it was 57.2 percent. The Medicare PPO rate in 2018 was 55.6 percent, and in 2020, it was 59.6 percent.[2] These results, although for Medicare, indicate that improvement in the quality of health care delivery and outcomes can be achieved over time. Performance in the Medicare population varied across and within geographic regions, with an average performance rate of 47.5 percent (interquartile range [IQR] = 41.6 to 55.3 percent) among plans in the lowest performing region (New Jersey, New York, Puerto Rico, and US Virgin Islands) and 56.4 percent (IQR = 52.7 to 61.8 percent) among plans in the highest performing region (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont).[3]
How measure can be used to monitor improvement	The WGM noted that the measure could be trended over time to monitor improvement.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid beneficiaries	The WGM noted that Medicaid beneficiaries must have two or more chronic conditions, one chronic condition and be at risk of developing another, or one serious and persistent mental health condition in order to qualify for health home services. For the FFY 2020 measurement period, there were 10 approved health home programs targeting individuals with multiple chronic conditions serving approximately 38 percent of all health home enrollees. There were also 18 health home programs targeting individuals with serious mental illness/serious emotional disturbance (SMI/SED) or substance use disorder (SUD) serving approximately 13 percent of all health home enrollees. Finally, there were seven hybrid health home programs with two or more focus areas (for example, chronic conditions and SMI/SED or chronic conditions and SUD); these seven programs served 49 percent of all health home enrollees.
Use of measure in other CMS programs	Medicare Advantage Quality Improvement Program
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM did not identify any barriers that states could face in calculating this measure for the Health Home Core Set. However, this measure would need to be specified for the Medicaid health home population by the measure steward.

Citations

[1] National Committee for Quality Assurance. (2020, December 28). *Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions*. NCQA. Retrieved April 28, 2022, from https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/.

[2] Ibid.

[3] Centers for Medicare and Medicaid Services. (n.d.). *Follow-up after Emergency Department (ED) Visit for Patients with Multiple Chronic Conditions*. Centers for Medicare and Medicaid Measure Inventory Tool. Retrieved April 28, 2022, from https://cmit.cms.gov/cmit/#/MeasureView?variantId=5195§ionNumber=1.