Introduction to the Core Set of Health Care Quality Measures for Medicaid Health Home Programs

Technical Assistance Webinar
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Agenda

• Welcome
• Introduction to Health Homes Program and Quality Reporting
• Core Set of Medicaid Health Home Measures for FFY 2013 Reporting
• Availability of Technical Assistance
• Overview of FFY 2013 Measure Reporting
• Q&A
  • Please send questions through the Q&A function during the webinar
Introduction to Health Homes Program and Quality Reporting
Background

• Health Homes are a service delivery model for providing a longitudinal “home” to facilitate access to medical care, behavioral health care, and community-based social services for adults and children with chronic conditions

• Eligibility:
  • Two chronic conditions (asthma, diabetes, heart disease, obesity, mental condition, and/or substance abuse disorder)
  • One chronic condition and risk of a second
  • One serious and persistent mental health condition
States with Health Home Programs

- **Approved Health Home State Plan Amendment (SPA)** (where #: number of approved SPAs if more than one exists)
- **Health Home SPA “On the Clock”** (officially submitted to CMS)
  - Iowa (3rd SPA), Maine (2nd SPA), Ohio (2nd SPA), Wisconsin (2nd SPA)
- **Approved Health Home Planning Request**
- **No Proposed SPA Submitted to CMS**

*Some states may be in the planning phase*
Health Home Quality Reporting

• Two-part quality reporting
  • Core measures
  • State-specific goals

• Independent evaluation
  • Reducing hospitalization
  • Reducing emergency room visits
  • Reducing admissions to skilled nursing facilities
Health Home Core Set

- To identify the Health Home Core Set, CMS consulted with states considering health homes and conducted technical assistance calls, presentations, and webinars
- CMS also worked with federal partners
- Core Set measure selection
  - Key priority areas (behavioral health and preventive care)
  - Align with existing core sets (Adult and Child)
  - Based on claims data to the extent possible
- In January 2013, CMS announced the Health Home Core Set (eight measures)
  - Three utilization measures added to assist with evaluation
Health Home Core Set Measures

- Adult Body Mass Index (BMI) Assessment (HEDIS)*
- Screening for Clinical Depression and Follow-up Plan (CMS)*
- Plan All-Cause Readmission Rate (HEDIS)*
- Follow-up After Hospitalization for Mental Illness (HEDIS)*#
- Controlling High Blood Pressure (HEDIS)*
- Care Transition – Timely Transmission of Transition Record (AMA-PCPI)*
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)*
- Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (AHRQ)

*Included in Adult Core Set
#Included in Child Core Set
Health Home Utilization Measures

- Ambulatory Care – Emergency Department Visits (HEDIS)
- Inpatient Utilization (CMS)
- Nursing Facility Utilization (CMS)
General Adaptation of Measures

• Reporting Unit – Health Home Program defined by the State Plan Amendment

• Measure Terminology
  • Health Home Program
  • Health Home Provider
  • Health Home Enrollee

• Alternative Data Sources and Collection
  • Patient registry
  • E-measure if available
## Data Sources for Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Admin</th>
<th>Hybrid/Medical Record</th>
<th>EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI Assessment</td>
<td>X</td>
<td>X</td>
<td>-</td>
</tr>
<tr>
<td>Depression Screening and Follow-up</td>
<td>-</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Plan All-Cause Readmission</td>
<td>X</td>
<td>-</td>
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<tr>
<td>Follow-up After Hospitalization for Mental Illness</td>
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<tr>
<td>Controlling High Blood Pressure</td>
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<td>Care Transitions</td>
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<td>AOD Dependence Treatment</td>
<td>X</td>
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<tr>
<td>PQI 92: Chronic Conditions Composite</td>
<td>X</td>
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General Adaptation of Measures Cont’d

• Age Range and Stratification
  • Include reporting on children for applicable measures
  • Stratified by <18, 18-64, and 65+, and total

• Measurement Timeframe
  • January 1- December 31, 2012 (for FFY 2013 reporting)
  • Harmonized with Adult Core Set

• Eligible Population
  • Enrollment is determined by date of enrollment in Health Home Program and assignment to Health Home Provider
  • Enrollees who drop out of Health Home Program or switch Health Home Programs are no longer considered enrolled in the program
## Continuous Enrollment Criteria

<table>
<thead>
<tr>
<th>Measure</th>
<th>Continuous Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan All Cause Readmission</td>
<td>365 days prior to discharge date through 30 days after discharge</td>
</tr>
<tr>
<td>BMI Assessment</td>
<td>12 months*</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>12 months</td>
</tr>
<tr>
<td>Initiation and Engagement of AOD Dependence Treatment</td>
<td>60 days prior to index episode through 44 days after index episode</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness</td>
<td>Date of discharge and 30 days after discharge</td>
</tr>
<tr>
<td>Care Transitions</td>
<td>Date of discharge</td>
</tr>
<tr>
<td>PQI 92: Chronic Conditions Composite</td>
<td>None</td>
</tr>
</tbody>
</table>

*12 month continuous enrollment criteria apply only to FFY2013 reporting*
Core Set Measure Example: Follow-Up After Hospitalization for Mental Illness

• Description: The percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:
  • The percentage of discharges for which the patient received follow-up within 30 days of discharge.
  • The percentage of discharges for which the patient received follow-up within 7 days of discharge.
Core Set Measure Example Cont’d

• Guidance for Reporting
  • Age stratifications
  • Inclusion of all claims

• Definitions
  • Mental health practitioner

• Eligible Population
  • Age: 6-17, 18-64, 65+, total
  • Continuous Enrollment: 30 days after discharge
  • Allowable Gap: None
  • Event/Diagnosis: Discharged alive from an acute inpatient setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year
    • Additional guidance on handling transfers
    • Tables of codes
Core Set Measure Example Cont’d

• Administrative Specification
  • Denominator
    • Eligible Population
  • Numerators
    • An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner:
      • Within 30 days after discharge
      • Within 7 days after discharge
    • Tables of codes

• Additional Notes
  • Guidance on different methods for billing intensive outpatient encounters and partial hospitalizations
Questions?
Availability of Technical Assistance
Requesting Technical Assistance (TA) for Health Home Core Set Measures

• Goal of TA is to help clarify the measure specifications; answer questions about reporting the Health Home measures; and help states use data from measures to drive quality improvement

• Of the measures that overlap with Adult Core Set, most frequent TA requests were related to Care Transitions, Plan All-Cause Readmission, and PQI measures

• States may submit TA requests to the TA mailbox (MACqualityTA@cms.hhs.gov)

• Suggestions are welcome for other TA resources, such as webinars, fact sheets, or TA briefs
Overview of FFY 2013 Reporting
Heath Home Core Set Reporting

- CMS will be using a web-based reporting system, known as CARTS, similar to the system used for the Child and Adult Core Sets.
- States will report Health Home measures into CARTS for FFY 2013.
  - CMS will provide additional information about the timeline for CARTS reporting at a later date.
- Data will be reported at the State Plan Amendment (SPA) level.
- Data should be reported for CY 2012, FFY2013 Reporting.
CARTS Preview
Questions?
Wrap-up
Resources

• Health Homes TA website on Medicaid.gov

• State Medicaid Director letter on Health Home Core Quality Measures, 1/15/2013

• Technical Specifications and Resource Manual for FFY 2013 Reporting of the Health Home Core Set

• For TA related to the Health Home Core Set measures:
  • Contact the TA mailbox at MACqualityTA@cms.hhs.gov
Questions?

Thank you for participating in today’s webinar!

Please complete the evaluation as you exit the webinar.