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

Technical Assistance Webinar
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Medicaid/CHIP
Health Care Quality Measures

Agenda

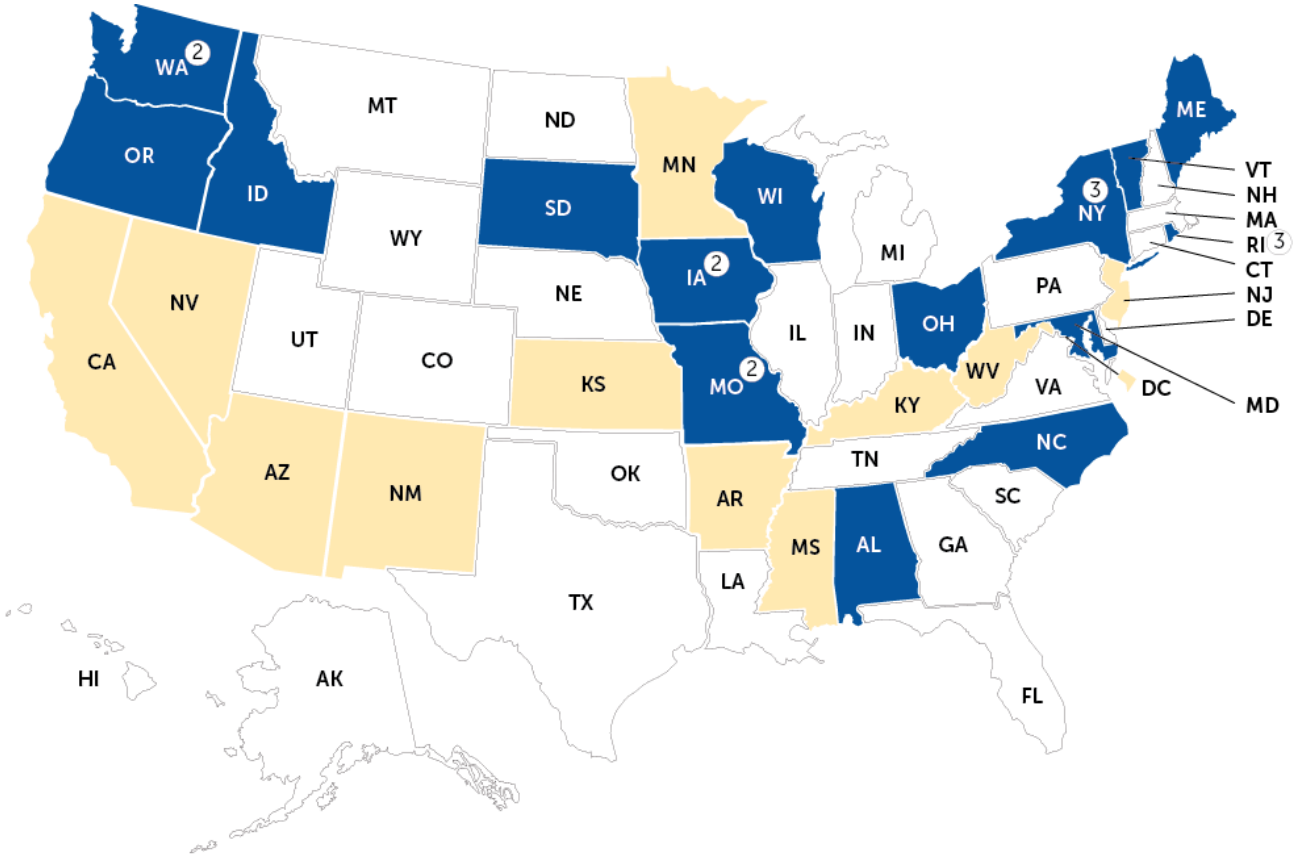
- Welcome
- Introduction to Health Homes Program and Quality Reporting
- Core Set of Medicaid Health Home Measures for FFY 2013 Reporting
- Availability of Technical Assistance
- Overview of FFY 2013 Measure Reporting
- Q&A
  - Please send questions through the Q&A function during the webinar

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

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Health Care Quality Measures

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

Core Set of Health Care Quality Measures for Medicaid Health Home Programs: Technical Specifications and Resource Manual for FFY 2013 Reporting

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

	Admin	Hybrid/ Medical Record	EHR
BMI Assessment	X	X	-
Depression Screening and Follow-up	-	X	X
Plan All-Cause Readmission	X	-	-
Follow-up After Hospitalization for Mental Illness	X	-	-
Controlling High Blood Pressure	-	X	X
Care Transitions	-	X	-
AOD Dependence Treatment	X	-	X
PQI 92: Chronic Conditions Composite	X	-	-

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

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

*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
  - http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html
- State Medicaid Director letter on Health Home Core Quality Measures, 1/15/2013
  - http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf
- Technical Specifications and Resource Manual for FFY 2013 Reporting of the Health Home Core Set
  - http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-home-core-set-manual-.pdf
- 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!

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