

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

SCAN: Jennifer  
Sara Bradford  
Vicky Ducewaph  
Nicole  
Nate  
Erwin

**ACTION REFERRAL**

Redlogged from Waldrip to Roy on 2-1-13 per Annie.

TO <b>Roy</b>	DATE <b>1-25-13</b>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <b>000229</b> <b>000229</b>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR  <b>cc: Mr. Keck, COS, Deps, CUS</b> <b>file</b>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action - <b>2014 contract</b> <b>MOE for SEDUE</b>

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			<p>Brenda, Please re-log to Roy. Thank you.  1/30/13</p>
2.			
3.			
4.			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR**

**ACTION REFERRAL**

TO <i>Wafdrop</i>	DATE <i>1-25-13</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>101229</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Keck, COO, Deps, CMS file</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Vicky Duckworth

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850

**RECEIVED**

JAN 23 2013

Department of Health & Human Services  
OFFICE OF THE DIRECTOR



SMD# 13-001  
ACA #23

Re: Health Home Core Quality Measures

January 15, 2013

Dear State Medicaid Director:

The health home provision authorized by section 2703 of the Affordable Care Act provides an opportunity to build a person-centered care delivery model that focuses on improving outcomes and disease management for beneficiaries with chronic conditions and obtaining better value for state Medicaid programs. As part of this care improvement effort and after extensive consultation with states and other stakeholders, the Centers for Medicare & Medicaid Services (CMS) is sharing a recommended core set of health care quality measures for assessing the health home service delivery model that CMS intends to promulgate in the rulemaking process.

While CMS is not requiring states to use these measures until the regulations are promulgated, states requested that we share these measures in advance of rulemaking. In keeping with the collaborative process on the health home provision, CMS is sharing the core set to help states as they consider the design and implementation of their health home programs. This advance notice will also give states time to share information with their health care providers, which is important, since health home providers will be required to report health care quality measures in order to receive payment.

These recommended health home core quality measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for beneficiaries. This effort is aligned closely with the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement in Health Care, as well as other quality initiatives.

CMS consulted with states considering health homes and conducted technical assistance calls, presentations, and webinars in order to identify the initial core set of health home quality measures for Medicaid-eligible children and adults. CMS also worked with federal partners, including the Office of the Assistant Secretary for Planning and Evaluation and the Substance Abuse and Mental Health Services Administration. The recommended core set of health home measures were chosen because they reflect key priority areas such as behavioral health and preventive care, and they align with the initial core set of health care quality measures for Medicaid-eligible adults, the EHR incentive "Meaningful Use" program measures, and with the National Quality Strategy.

The recommended health home core measures are listed below and described in more detail in Attachment A:

1. Adult Body Mass Index (BMI) Assessment,
2. Ambulatory Care - Sensitive Condition Admission,
3. Care Transition – Transition Record Transmitted to Health care Professional,
4. Follow-up After Hospitalization for Mental Illness,
5. Plan- All Cause Readmission,
6. Screening for Clinical Depression and Follow-up Plan,
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,
8. Controlling High Blood Pressure.

To ease the reporting burden, CMS has aligned all but one of the recommended health home core set of measures with the initial core set of health care quality measures for Medicaid-eligible adults, which were published and posted for public comment on December 30, 2010, with final regulations published on January 4, 2012. CMS encourages states to report on the initial core set of children's health care quality measures<sup>1</sup> and the initial core set of health care quality measures for Medicaid-eligible adults.<sup>2</sup>

The recommended health home measures are drawn from claims data, to the extent possible, in order to reduce burden on states. However, CMS recognizes that certain measures in the core set require data extractions from medical records, and may require additional work for some providers and states. CMS will provide state Medicaid agencies with the technical specifications for the core measures (e.g., numerator, denominator, and coding information) and will encourage states to delay system programming for the health home quality measures until these specifications are released. The purpose of the recommended health home core set is to assess health outcomes specific to the health home program. The health home core set will require reporting at the health home provider level, while the full Medicaid-eligible adult core set of health care quality measures will be reported in the aggregate at the state level. CMS will provide technical assistance on the implementation of these recommended health home measures and intends to release guidance on when states should begin reporting on the measures, the frequency of reporting, and the reporting mechanism.

The health homes core set of quality measures will be used to evaluate care across all state health home programs. CMS expects that states will report on the health home core measures, as well as the specific goals and measures identified by individual states. The intent of the two part quality reporting approach is to gain consistency across states while allowing states to use existing quality metrics to measure health home outcomes. All of the quality data will be utilized by CMS to work with states and other stakeholders to continually improve health homes. The data will also be used to inform the evaluations that section 2703 of the Affordable Care Act

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<sup>1</sup> Initial core set of children's health care quality measures State Health Official letter, <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO11001.pdf>

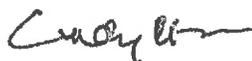
<sup>2</sup> Initial core set of health care quality measures for Medicaid-eligible adults, Federal Register / Vol. 77, No. 2 / Wednesday, January 4, 2012. <https://www.federalregister.gov/articles/2012/01/04/2011-33756/medicaid-program-initial-core-set-of-health-care-quality>

require, in both an interim survey of states and an independent evaluation in the 2014 and 2017 reports to Congress.

For states interested in health homes, more information is available at the following link: <http://www.medicaid.gov/AffordableCareAct/Provisions/Quality-of-Care-and-Delivery-Systems.html>. States interested in receiving technical assistance may also e-mail the CMS health homes team at [healthhomes@cms.hhs.gov](mailto:healthhomes@cms.hhs.gov).

If you have any questions regarding the health home core measure set, please contact Ms. Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,



Cindy Mann  
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health Operations

Matt Salo  
Executive Director  
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.  
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Robert Glover, PhD  
Executive Director  
National Association of State Mental Health Program Directors

Robert Morrison  
Executive Director  
National Association of State Alcohol and Drug Directors

Attachment A- Health homes Core Measure Set

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
N/A	1. Adult Body Mass Index (BMI) Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year	<p><b>Numerator Description</b> Body mass index documented during the measurement year or the year prior to the measurement year</p> <p><b>Denominator Description</b> Members 18-74 of age who had an outpatient visit</p>	Medicaid Adult Core Set, HEDIS
N/A	2. Ambulatory Care-Sensitive Condition Admission	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.	<p><b>Numerator Description</b> Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years</p> <p><b>Denominator Description</b> Total mid-year population under age 75</p>	
643	3. Care Transition – Transition Record Transmitted to Health care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	<p><b>Numerator Description</b> Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> <p><b>Denominator Description</b> All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care</p>	Medicaid Adult Core set

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0576	4. Follow-Up After Hospitalization for Mental Illness	<p>Percentage of discharges for members 6 years of age 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 within 7 days of discharge.</p>	<p><b>Numerator Description</b>  An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.</p> <p><b>Denominator Description</b>  Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year</p>	Children's Core Set, Medicaid Adult Core Set, HEDIS
1768	5. Plan-All Cause Readmission	<p>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.</p>	<p><b>Numerator Description</b>  Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination</p> <p><b>Denominator Description</b>  Count the number of Index Hospital Stays for each age, gender, and total combination</p>	Adult Core set, HEDIS

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0418	6. Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	<p><b>Numerator Description</b> Total number of patients from the denominator who have follow-up documentation</p> <p><b>Denominator Description</b> All patients 18 years and older screened for clinical depression using a standardized tool</p>	PQR, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core set, Meaningful Use 2

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0004	7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	<p>Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> <li>• Initiation of AOD treatment.</li> <li>• Engagement of AOD treatment.</li> </ul>	<p><b>Numerator Description</b> Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.</p> <p><b>Engagement of AOD Treatment:</b> 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). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p><b>Denominator Description</b> Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p>	<p>Meaningful Use 1 and 2, Medicaid Adult Core set, HEDIS</p>

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0018	8. Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	<p><b>Numerator Description</b> The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be &lt;140/90mm Hg.</p> <p><b>Denominator Description</b> Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.</p>	Million Hearts, Medicaid Adult Core set, Meaningful Use 2, ACO Measure