



ILLINOIS HEALTH HOMES INITIATIVE CONCEPT PAPER

Section 2703 of the Affordable Care Act created opportunities for states to develop health home services. The Health Home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid clients with chronic conditions. Health Home providers must integrate and coordinate all primary, acute, behavioral health and long-term services and supports.

Illinois Medicaid has submitted a State Plan Amendment to federal CMS, based on the policies and procedures outlined in this Concept Paper. If the State Plan Amendment is approved for Illinois, Federal CMS will provide a 90% enhanced match for the Health Home comprehensive care coordination services, but only for 8 quarters. Accordingly, Illinois Medicaid waited until the conclusion of the care coordination roll-out to begin this Health Homes Initiative. It is expected that Health Homes will be developed and put into operation by October, 2015. Additional stakeholder meetings will be organized to discuss this further.

1. How Health Home Services Are Provided

Illinois Medicaid has been primarily a fee-for-service system, involving thousands of healthcare providers who have provided invaluable healthcare services and social supports to low-income individuals and families for many years. Aligned with national healthcare reform, the State of Illinois has embraced the vision of the Triple Aims: improving the experience of care, improving the health of populations, and reducing the growth in health care costs.

To accomplish the Triple Aim, Illinois Medicaid is in the process of implementing a redesign of the Medicaid healthcare delivery system. This ambitious redesign will move Illinois from a fundamentally fee-for-service system to a system that aggressively promotes care coordination, payment reform and health outcomes. The new system incentivizes providers, community-based organizations, and traditional managed care organizations to work together to coordinate care and improve the experience and quality of care received by Illinois Medicaid clients. Illinois is unique in the nation with the development of innovative Managed Care Entity (MCE) models:

- **Care Coordination Entities (CCE):** CCEs are a collaboration of providers and community agencies, governed by a lead entity that receives a care coordination payment in order to provide care coordination services for its enrollees (medical services are still fee-for-service). A CCE may serve Seniors and Persons with Disabilities, Children with Special Needs, or ACA Adults. A CCE must have a network of providers and community partners who shall deliver coordinated quality care across provider and community settings to Enrollees. The Enrollee shall be at the center of the CCE's coordinated care network and delivery system. The CCE shall coordinate care across the spectrum of the healthcare system with emphasis on managing transitions between levels of care and coordination with community and social services..
- **Managed Care Community Networks (MCCN):** A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides primary, secondary and tertiary managed health care services under a risk-based capitation arrangement. MCCNs are subject to aggressive care coordination contract standards that require assignment of an interdisciplinary care team of health professionals to Enrollees. The interdisciplinary care team must coordinate care across the continuum of the healthcare system and with community and social service organizations to ensure the Enrollee is at the center of the delivery system. MCCNs are monitored and eligible for incentive payments for meeting quality measures. MCCNs may serve individuals enrolled in all eligibility categories (SPD, FHP, ACA Expansion, etc.).
- **Managed Care Organizations (MCO):** MCOs operating in Illinois provide the full range of Medicaid services under a capitated payment arrangement. MCOs must be recognized by the Illinois Department of Insurance. MCOs are subject to aggressive care coordination contract standards that require assignment of an interdisciplinary care team of health professionals to Enrollees. The interdisciplinary care team must coordinate care across the continuum of the healthcare system and with community and social service organizations to ensure the Enrollee is at the center of the delivery system. MCOs are monitored and paid according quality measures. MCOs serve individuals enrolled in all eligibility categories.
- **Accountable Care Entities:** An ACE is an organization comprised of and governed by its participating providers, with a legally responsible lead entity, that receives a care coordination payment to coordinate the care of its Enrollees (medical services are still fee-for-service for the first 18 months, and take on financial risk thereafter), and is accountable for the quality, cost, and overall care of its Enrollees. An ACE cannot be an insurance plan. The ACE demonstrates an integrated delivery system, shares clinical information in a timely manner, and designs and implements a model of care and financial management structure that promotes provider accountability,

quality improvement, and improved health outcomes. ACEs generally serve children, families, pregnant women, and newly eligible ACA Adults.

The Illinois Health Home program builds on its redesigned delivery system and leverages the infrastructure and the strong care coordination models already in place within the Managed Care Entities' (CCE, MCCN, MCO, and ACE) networks.

Individuals eligible for Health Homes will be defined by the State. Eligible individuals will be provided Health Home services by the Managed Care Entity (Health Home), which they are enrolled for the provision of Medicaid services and/or care coordination services under the redesigned Medicaid delivery system in Illinois. Eligible individuals will have the option to opt-out of receiving Health Home services or to switch Health Homes.

2. Geography

Health Homes will operate in the following service areas:

- a. Greater Chicago (including Cook and 5 collar counties)
- b. Rockford (tier of 3 northern Illinois counties)
- c. Quad Cities (3 counties in the Rock Island-Moline area)
- d. Central Illinois (15 county region including cities of Springfield, Bloomington, Campaign, and Peoria)
- e. Metro East (3 Illinois counties in St. Louis area)

3. Population Criteria

The State will provide health home services to individuals with:

- Two Chronic Conditions
- One chronic condition and at risk for developing another
- Chronic conditions include:
 - Mental Health condition
 - Substance Abuse
 - Asthma
 - Diabetes
 - Heart Disease
 - BMI over 25, at which time data is available
 - Other chronic conditions include: Illinois will target populations for Health Homes services in the major categories and the associated 3M™ Clinical Risk Grouping categories of chronic behavioral and medical conditions listed below.

Major Category: Substance Use Disorders

Major Category: Mental Health

1. Schizophrenia
2. Schizoaffective Disorder
3. Other psychotic disorders
4. Delusional Disorder
5. Bipolar Disorder
6. Depressive and other mood disorders
7. Severe anxiety disorders
8. Eating disorders
9. Impulse control and conduct disorders
10. Dissociative Disorders
11. Trauma and Stressor-Related Disorder
12. Major Neurocognitive Disorder

Major Category: Cardiovascular Disease

1. Advanced Coronary Disease
2. Cerebrovascular Disease
3. Congestive Heart Failure
4. Hypertension
5. Peripheral Vascular Disease

Major Category: HIV/AIDS

1. HIV Disease

Major Category: Metabolic Disease

1. Chronic Renal Failure
2. Diabetes

Major Category: Respiratory Disease

1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other

1. Other Chronic Disease – conditions listed above as well as other specific diagnoses of the population.

CRGs are based upon the classification of patient illness with particular emphasis upon chronic illness burden. The system uses administrative claims data, pharmacy data and functional health status assessments to provide consistent identification of Medicaid clients with chronic conditions and accompanying severity of illness. CRGs incorporate comprehensive edit rules for establishing when a chronic disease is reliably considered to be confirmed thus avoiding over-identification of the Health Home eligible population. Clients with multiple chronic conditions and those that are at high risk of additional chronic conditions or exacerbation of

current disease states are explicitly identified. The Health Home population can be identified using rules based upon application of the CRG algorithm with the categorical structure of the risk groups capable of isolating disease types through which to measure changes in spending per beneficiary, changes in the rate of adverse outcomes and changes in the rate of transition to worsening disease states.

3M's CRG software groups clients into risk categories by looking at utilization and resources used by those clients based on Illinois Medicaid claims data submitted by providers. It assigns clients to one of these categories using all the services utilized by the client including inpatient, ambulatory care and pharmacy data for one year. There are 3 Aggregations of the CRGs with level 3 being the highest (ACRG3). The ACRG3 groups clients into levels 1 through 9 with level 1 being "Healthy" down to level 9 which are the clients with the "Catastrophic Conditions". Within each ACRG3 level there are varying degrees of severity of illness, 0 being the least severe and 9 being the most severe. Those clients who are at ACRG3 level 5 have one Chronic Condition and those ACRG3 level 5 clients who have a severity of illness level of 3 or more are considered "high risk" and are therefore at risk for another Chronic Condition. ACRG3 levels 6 through 9 are clients that are identified to have 2 or more Chronic Conditions, so therefore the State chose to identify those clients within ACRG3 levels of 5.3 through 9.9 who will benefit from the Health Homes services as Health Home eligible. Clients within those ACRG3 levels of 5.3-9.9 who have a severity of illness level of 3 or more are considered "high risk" and will therefore require more intensive care management services. Health Home services will be provided to all categorically eligible Medicaid recipients. For those individuals with no available utilization data, MCEs will screen individuals for Health Home services using a State-developed or approved screening tool. The State will monitor the MCEs use of the screening tool.

Individuals will receive Health Home services for a period of eight quarters at which time the State will reassess their CRG score. Health Home services will continue to be available for eligible individuals after the initial eight quarters.

The State plans to implement health homes on October 1, 2015.

4. Provider Infrastructure

Health Homes will be a designated provider as defined in Section 1945(h)(5) of the Act. The designated provider will work with a multi-disciplinary team of health professionals including representation from the medical, behavioral health, social and community service, and, as applicable, long-term care sectors to provide health home services. The team of health professionals will include physicians and other professionals such as a nurse practitioner, nutritionist, social worker, behavioral health professional, peer support specialist, outreach worker, or a pharmacist. The designated provider will be the Managed Care Entity.

Entities eligible to become health homes in Illinois are the Managed Care Entities and include MCOs, MCCNs, CCEs, and ACEs. The designated provider will assign a team of health care professionals to work together under a formal agreement and agreed upon care coordination protocols to offer health home services as defined by the State. The delivery of health home services will be led by a designated care manager who will assure that enrollees receive medical, behavioral health, and social services under a single care plan, agreed upon among the team of health professionals. The care manager will be responsible for monitoring the care plan and ensuring goals are updated, as necessary. The State will provide initial and ongoing training and technical assistance to the MCEs (Health Homes).

5. Service Definitions

a. **Comprehensive Care Management** must at least include:

- i. **Individualized Care Plan.** For all Health Home Enrollees, Health Homes must provide an individualized, person-centered care plan developed based upon a comprehensive health risk and, if necessary, behavioral health risk assessment. The care plan must integrate an Enrollee's medical, behavioral health, long-term care, rehabilitative and social service needs, as appropriate. The care plan must clearly identify the primary care physician and any other providers involved in delivering care to the Enrollee as well as community networks and social supports. The care plan must include goals, timeframes, and action steps towards improving the Enrollee's overall health. The Enrollee must be an active participant in the development of the care plan. The care team will be required to play an integral role in the creation, monitoring, and updating of the care plan. The care team is the patient advocate and primary resource for both medical and social multidisciplinary communication.
- ii. **Integration of physical and behavioral health.** Health Homes will provide integrated physical and behavioral health services as appropriate to the Enrollees needs. Screenings for intimate partner violence, depression, and substance abuse should be part of the initial assessment. Enrollees should be screened using validated tools with appropriate and timely follow up and referrals. Inpatient and outpatient behavioral health treatment plans should be incorporated in the overall care plan.
- iii. **Family involvement.** Health Homes must provide the opportunity for family and/or caregiver involvement based on the Enrollee's preference. This includes the development, monitoring and

updating of the care plan, according to the Enrollee's needs and wishes.

- iv. Tracking care plan goals.** The care manager will be responsible for monitoring and tracking care plan goals, and working with the team of health professionals to update goals and interventions as necessary.
- v. Periodic reassessment.** Health Homes must periodically reassess an Enrollee's needs and update care plans as dictated in the MCE contracts or as needed based on changes in health status.
- vi. Care Manager to Enrollee Ratios.** Health Homes must have Care Manager to Enrollee Ratios appropriate to need.
- vii. Integration of Housing Services.** The Health Home must work with community organizations that provide supportive housing or other services related to homelessness or tenancy service.
- viii.** For health home eligible individuals the State identifies as high-risk, the Health Homes will be required to have smaller care manager to enrollee ratios.

b. Care Coordination must at least include:

- i. Adherence to treatment / medication monitoring.** The care manager is responsible for coordinating all necessary care and monitoring Enrollee adherence to the care plan, which includes medication monitoring. The Health Home must assure defined responsibilities among each health home team member and foster communication between the care manager and the members of the health home such as the treating clinicians to discuss the enrollee's needs. The health home must have defined accountabilities in place to assure effective collaboration among the health home members.
- ii. Referral tracking.** The Health Home must develop and/or utilize a system to share regularly updated clinical information and track referrals and care needs across providers, preferably using Certified Electronic Health Record Technology (CEHRT), meeting ONC Meaningful Use criteria and PCMH standards.

- iii. **Emphasis on face-to-face contacts.** The Health Home must have policies and procedures in place to ensure care managers engage in regular face-to-face contact with enrollees.
- iv. **Use of case conferences.** The Health Home must have policies and procedures in place to ensure regular case reviews with all members of the care team.
- v. **Tracking test results.** The Health Home must have systems in place to track test results and ensure those results are accessible to all members of the care team.
- vi. **Requiring discharge or transition of care summaries.** The Health Home will require use of discharge summaries that are incorporated into the care plan and accessible to all members of the care team, preferably using CEHRT and HIE.
- vii. **Automated notification of admission.** The Health Home will develop a system to notify care team members when an Enrollee is discharged from the ED or is admitted to a hospital.
- viii. **Housing coordination.** Health homes will provide housing coordination assistance as necessary.
- ix. For high-risk enrollees identified as needing enhanced Health Home services, the Health Home must ensure regular face-to-face contact between the care manager and enrollee as appropriate to coordinate the enrollee's care. The State also encourages health homes to perform a home visit from someone from the care team during the development of the care plan, and periodic home visits in order to monitor and update care plans.

c. **Health Promotion** must at least include:

- i. Development of self-management plans through the individualized care plan and the referral to needed resources such as smoking cessation, self-help recovery, or management of chronic diseases.
- ii. Evidence-based wellness and promotion through enrollee health education via methods such as one on one teaching, group therapy, and peer support.

- iv. Enrollees, families, and caregivers are provided information on the use of advance directives and end of life wishes are discussed and documented if applicable.
 - v. Family/caregivers are involved with patient centered plans including peer supports if applicable.
 - vi. Assistance with attaining highest level of functioning in the community.
 - vii. Encouraging home and community based service integration by maximizing social supports with Enrollee's preferred networks.
- f. **Referral to Community and Social Support Services.** The Health Home will actively identify community-based resources and manage appropriate referrals to community-based resources including follow-up. The Health Home will place an emphasis on identifying resources closest to home and least restrictive. The Health Home may also consider developing a resource manual. The Health Home must have policies, procedures, and accountabilities with community-based organizations to ensure effective collaborations and coordination of care.
- g. **Linking Services Through HIT.** Health Homes will be required to utilize CEHRT and HIE as feasible to improve service delivery and coordinate care across the continuum. Health Homes must have policies and procedures in place that allow members of a care team to securely share clinical information, track referrals and to access to a single care plan. Health Homes are encouraged to use CCD compliant HIT to provide notification to care team members of ED and inpatient hospital admissions. The State understands that some providers in a Health Home network may not utilize HIT. As such, the State encourages MCOs, MCCNs, CCEs (and requires ACEs) to utilize the Illinois Health Information Exchange (ILHIE). Utilization of the ILHIE will allow care team members to securely share clinical information.

6. Provider Standards

In Illinois, a Health Home provider is the central point in coordinating an Enrollee's care including medical, behavioral, and social need. A Health Home provider is responsible for reducing preventable inpatient admission/readmissions; preventing avoidable ED visits; improving quality outcomes while reducing overall per capita cost. A Health Home must:

- Assign a team of health professionals to coordinate an Enrollee's care. Providers must be enrolled in the Illinois Medicaid program and comply with all program requirements.
- Assign care managers with the qualifications, education, and professional experience to meet the needs of the Enrollee. For example, Enrollees with

complex medical needs may be assigned a RN care manager and Enrollees with behavioral health needs may be assigned a LCSW.

- Be capable of providing or contracting for the provision of all Health Home services required in its contract. The Health Home is ultimately responsible for all subcontracted activities.
- Include hospitals in its network and have policies and procedures in place to refer any Health Home Enrollee who seeks or needs treatment in a hospital ED to the appropriate outpatient provider and to include the care manager in the referral process.
- Have policies and procedures in place to meet the Health Information Technology (HIT) requirements. MCOs must also have in place oversight and monitoring structures for those MCOs that subcontract the provision of Health Home services. The State will review and assure these policies and procedures are in place prior to implementation.

7. Payment Methodologies

The State, in its redesigned delivery system, has created Health Homes in each type of Managed Care Entity (MCEs). All MCEs are essentially responsible for the overall quality and cost of care delivered and must implement similar health home service requirements. Taking into consideration that all MCEs are Health Homes, the State proposes the following payment methodologies.

- a. MCOs/MCCNs:** The MCOs and MCCNs operate under a risk-based payment arrangement. A portion of the capitation payment (care coordination component) is designed to cover the provision of the contractual health home services. Because not all Enrollees in a MCO or MCCN will be identified as health home eligible, the State proposes to cost allocate the care coordination component included in the capitation rates for all clients and attribute more of the care coordination fees to the health home populations. The State will withhold a percentage of the amount cost allocated to Health Homes that the MCOs and MCCNs can earn back for meeting process or quality measure targets. The State will request 90 percent match on the cost allocated amounts including the amount earned back for meeting process or quality measure targets. The State is requesting 90 percent match on the cost allocated amounts to health home clients. This proposal is based on the fact that MCOs and MCCNs will spend more of the care coordination component of the capitation rate on providing health home services to health home populations. The State's actuary will be engaged to complete this analysis. All MCEs will be monitored by the State and its EQRO to assure Health Home eligible enrollees receive the robust level of care coordination they need and the Plan is contractually required to provide.

For the high-risk Health Home populations, MCOs and MCCNs will be required to provide additional services beyond what is currently assumed in the capitation rates. For the high-risk Health Home populations, the State will be paying an additional fee for outreach and engagement activities. MCOs and MCCNs must submit a claim for this payment upon completion of each high-risk Health Home Enrollee's care plan. The State will request 90 percent match on this additional fee for outreach and engagement activities.

- b. ACEs.** ACEs currently receive a flat care coordination fee for all Enrollees regardless of whether the individual is Health Home eligible. Similar to the proposal above, because the majority of care coordination activity will be provided to Health Home eligible individuals, the State proposes to cost allocate the care coordination fees for all clients and attribute more of the care coordination fees to the health home populations. The State will institute a withhold against the cost allocated amounts that the ACEs may earn back for meeting process or quality measure targets. The State will request 90 percent match on the cost allocated amounts attributed to Health Home clients including the amounts earned back for meeting process or quality measure targets.

For high-risk Health Home populations, the State will provide an additional fee to the ACEs for outreach and engagement activities not assumed in the original care coordination fees upon care plan completion. ACEs must submit a claim for this payment upon completion of each high-risk Health Home Enrollee's care plan. The State will request 90 percent match on this additional fee.

- c. CCEs.** The CCEs generally serve Seniors and Persons with Disabilities with greater care needs or Children with Special Needs and have smaller enrollments. CCEs currently receive a flat care coordination fee for all Enrollees. The CCE care coordination fees assume all levels of health home services including those high-touch services required for the high-risk Health Home individuals. Because the majority of care coordination activity will be provided to Health Home eligible individuals, the State proposes to cost allocate the care coordination fees for all clients and attribute more of the care coordination fees to the Health Home populations. The State will institute a withhold against the cost allocated amounts that the CCEs may earn back for meeting process or quality measure targets. The State will request 90 percent match on the cost allocated amounts attributed to Health Home clients including the amounts earned back for meeting process or quality measure targets.

8. Monitoring

Below are the methodologies the State will use to monitor avoidable hospital readmissions and for calculating cost savings.

- a. **Tracking avoidable hospital readmissions.** To be provided at a later date.
- b. **Method for calculating cost savings.** To be provided at a later date.

9. Evaluations

- a. **Hospital Admission Rates.** The State will use Medicaid clean claims data and Managed Care encounter data that have been adjudicated in the MMIS system and extracted from the EDW and 3M's Potentially Preventable Admissions (PPA) software using CRGs to risk adjust the Health Home and clinically comparable populations.
- b. **Chronic Disease Management.** The State will monitor chronic disease management through contractually defined quality measures.
- c. **Coordination of Care for Individuals with Chronic Conditions.** The State will monitor coordination of care for individuals with chronic conditions through quality measures, encounter data, and regular reporting of care coordination activities.
- d. **Assessment of Program Implementation.** The State will monitor program implementation through regular meetings with the MCEs, and monthly, quarterly and annual reporting.
- e. **Processes and Lessons Learned.** The State will monitor program implementation and identify processes and lessons learned through regular meetings with the MCEs, quarterly and annual reporting, and regular stakeholder meetings.
- f. **Assessments of Quality Improvements and Clinical Outcomes.** The State will monitor and assess quality improvement processes and clinical outcomes through its Bureau of Quality Management, deployment of the External Quality Improvement Organization (EQRO), as appropriate, and contractually defined quality measures.
- g. **Estimates of Cost Savings.** Using the historic Illinois Medicaid claims data and managed care encounter data and 3M's CRG software, the State will develop methodologies for analyzing trends in the Health Home population's morbidity, utilization and cost and compare them to a comparable

nonintervention population. Then the State will retrospectively assess changes in these trends, which are attributable to the Health Home program in order to quantify the program's long-term value. The State will not only be tracking cost savings but also long term population health outcomes.

10. Quality Measures. The table below depicts the quality measures the State will use to monitor Health Homes.

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Program Measures
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>Numerator Description: Body mass index documented during the measurement year or the year prior to the measurement year.</p> <p>Denominator Description: Member 18-74 years 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>Numerator Description: Total number of acute care hospitalizations for ambulatory care sensitive conditions under the age of 75 years.</p> <p>Denominator Description: Total mid-year population under 75 years.</p>	
648	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 care physician or other health care professional designated for follow-up care within 24 hours of discharge.	<p>Numerator Description: Patient for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge.</p> <p>Denominator Description: All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or</p>	Medicaid Adult Core Set.

			rehabilitation facility) to home/self-care or any other site of care.	
0576	4. Follow-up After Hospitalization for Mental Illness	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>Numerator Description: An outpatient visit, intensive outpatient encounter, or partial hospitalization 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>Denominator Description: 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 31 of the measurement year.</p>	Children's Core Set, Medicaid Adult Core Set, HEDIS
1768	5. Plan- All Cause Readmission	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>Numerator Description: County the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination.</p> <p>Denominator Description: Count the number of Index Hospital Stays for each age, gender, and total combination.</p>	Medicaid Adult Core Set, HEDIS
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 toll AND follow-up documented.	<p>Numerator Description: Total number of patients from the denominator who have follow-up documentation.</p> <p>Denominator Description: All patients 18 years and older screened for clinical depression using a standardized tool.</p>	PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core Set, Meaningful Use Stage 2
0004	7. Initiation	Percentage of adolescent and	Numerator Description:	Meaningful Use Stages

	and Engagement of Alcohol and Other drug Dependence Treatment	adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: <ul style="list-style-type: none"> • Initiation of AOD treatment. • Engagement of AOD treatment 	<p>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>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 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>Denominator Description: 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 the total rate. The total rate is the sum of the two numerators divided by the sum of the twp denominators.</p>	1 and 2, Medicaid Adult Core Set, HEDIS.
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>Numerator Description: 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 < 140/90mm Hg.</p> <p>Denominator Description: Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN</p>	Million Hearts, Medicaid Adult Core Set, Meaningful Use Stage 2, ACO Measure.

			during the first six months of the measurement year.	
		Percent of members in the Plan who had a Health Risk Assessment completed within __ days of auto-assignment or enrollment; percentage of members determined Health Home eligible via HRA who had a person-centered care plan developed and in place within __ days of Health Home eligibility determination.		
		Percent of Health Home Eligible persons identified by HFS through 3M-CRG stratification who have a person-centered care plan developed and in place within __ days of Health Home eligibility notification of the Plan.		