Generic Supporting Statement

Clearance for Medicaid and CHIP Program (MACPro) Submissions
(CMS-10434, OMB 0938-1188)

Generic Information Collection (GenIC) #47
Health Home Core Sets

Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

A. Background

The Medicaid and CHIP Program (MACPro) data system is a web-based portal that automates the input and retrieval of data from the States related to the State Medicaid and CHIP Plans. This system supports an efficient workflow for the review and approval of the State Medicaid and CHIP adjudication process. States will access this system and submit program information into structured data templates. CMS staff will review the submission templates for compliance with Federal statute, regulation and policy, provide feedback to the States and track/monitor the review and approval process.

The Health Home Core Sets are currently approved under the generic clearance process under OMB control number 0938-1148 (CMS-10398 #47). Under that information collection request the Health Home Core Sets template was processed through one of our electronic web-based reporting systems known as the Medicaid Model Data Lab (MMDL). Electronic reporting in MMDL have now transitioned to MACPro to comport with regulatory requirements of a standardized template, which is periodically updated and formatted as specified by the Secretary. In addition, to reduce the burden for states, previously approved Health Home Core sets in MMDL were migrated into the MACPro system for states to use when they amend their Health Home Core sets. This transition is necessary since the MACPro system will become the sole system of record and supports CMS' initiative to improve processes by providing states with: reviewable units with built-in logic to ensure consistency across states and provide clear policy guidance; simplify templates that eliminate the need for many same page reviews; automate workflows to reduce unnecessary delay; clear, centralized communication processes; and improve transparency that allows states to check the status of their submissions.

Once approved under MACPro, the Health Home Core Sets information collection request will be removed from OMB control number 0938-1148 to avoid duplication of requirements and burden.

CMS acknowledges and understands that Crosswalks are typically required for delineating changes to reporting instruments. In this case, however, we are requesting an exemption from including any Crosswalks in this February 2019 iteration since the changes are limited to migrating from the MMDL legacy system to the MACPro system and the Crosswalk would be very difficult and burdensome to produce because the MMDL format is dramatically different from the MACPro structured data layout. Moreover, the Crosswalk would be somewhat useless since it would be very difficult for readers to understand and follow because of the extensive reordering and reformatting of the templates. Once this transition is approved, CMCS will be providing OMB with Crosswalks when changes are being proposed for our reporting instruments and/or instruction/guidance.

As part of the migration the Health Home quality specific measures were moved to separate quality and administrative reports within the MACPro system. We have also added a segment in the MACPro template that relates to ongoing quality in the monitoring section. This section also requests that states agree to adhere to assurance statements. While the reviewable units have been rearranged, their content remains unchanged.

While the reordering, reformatting, and adding of assurances increased the number of template pages the changes had no impact on any of our burden estimates.

B. Description of Information Collection

Information submitted via the Health Home Core Sets web-based application will be used by CMS Central and Regional Offices to implement Section 2703 of the Affordable Care Act (Public Law 111-148), entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions," creates a new opportunity for states to support improved integration of care for individuals with chronic conditions. Through the establishment of section 1945 of the Social Security Act, this provision allows states to elect a new Health Homes service option under the Medicaid state plan. This provision is an important opportunity for states to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness.

To support ongoing assessment of the effectiveness of the Health Home model, CMS has established a core set of Health Care Quality Measures (Health Homes Core Set). These recommended Health Home Core Set measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for beneficiaries. The Core Set will also be used to assess quality outcomes and performance, as well as to inform ongoing quality monitoring of the Health Home program. As authorized in 1945 of the Social Security Act, Health Home providers shall report on Health Home Quality measures as a condition for receiving payment for health home services. Health Home providers will be expected to report to the state Medicaid program, which will report the data in aggregate to CMS at the State Plan Amendment (SPA) level.

The Health Home Core Sets template in MACPro is separated into reviewable units that contain check-off items and free text areas for a State to describe its health home quality measures. The reviewable units (RUs) in the template include:
(1) Admin Data Source (see document HHQM1)
(2) Admin Hybrid Data Source (see document HHQM2)
(3) Admin Questions (see document HHQM3)
(4) Admin Screen (see document HHQM4)
(5) Combined Rates (see document HHQM5)
(6) Adult Body Mass Index Assessment (see document HHQM6)
(7) Ambulatory Care – Emergency Department Visits (see document HHQM7)
(8) Controlled High Blood Pressure (see document HHQM8)
(9) Clinical Depression and follow up Plan (see document HHQM9)
(10) Care Transition – Timely Transition of Transition Record (see document HHQM10)
(11) Follow-Up After Hospitalization for Mental Illness (see document HHQM11)
(12) Initiation and Engagement of Alcohol and other Drug Dependence Treatment (see document HHQM12)
(13) Inpatient Utilization (see document HHQM13)
(14) Nursing Facility Utilization (see document HHQM14)
(15) Plan All-Cause Readmission Rate (see document HHQM15)

(16) Preventive Quality Chronic Composite (see document HHQM16)
(17) State Specific Goals and Measures (see document HHQM17)
(18) Hybrid Data Source Screen (see document HHQM18)
(19) Hybrid or HER data (see document HHQM19)
(20) If Data Not Reported Screen (see document HHQM20)
(21) Technical Assistance Screen (see document HHQM21)

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 96,844 hours, and CMS previously requested to use 5,172 hours, leaving our burden ceiling at 91,672 hours.

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2018 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Medical and Health Services Manager	11-9111	54.68	54.68	109.36

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden (Time and Cost) Estimates

Annually, states will submit performance measure data on the seven (7) Health Home Core Set measures and three (3) utilization measures. Data is collected at the Health Home provider level and aggregated up to a health home program level rate for the state depending on how many Health Home programs a state has.

CMS estimates that each State will assign a medical and health services manager to complete the collection of data and submission to CMS within 40 hours at $109.36/hr. There is a potential universe of up to 30 respondents.

In aggregate, we estimate a burden of 1,200 hours (30 responses x 40 hours/response) at a cost of $131,232 (1,200 hr x $109.36/hr) or $4,374.40 per respondent ($131,232 / 30 respondents).

Information Collection Instruments and Instruction/Guidance Documents

HHQM1 – Admin-Data-Source.pdf (Revised)
HHQM2 – Admin-Hybrid-Data-Source.pdf (Revised)
HHQM3 – Admin-Questions.pdf (Revised)
HHQM4 – Admin-Screen.pdf (Revised)
HHQM5 – Admin-Combined-Rates.pdf (Revised)
HHQM6 – HHQM-ABA.pdf (Revised)
HHQM7 – HHQM-AMB.pdf (Revised)
HHQM8 – HHQM-CBP.pdf (Revised)
HHQM9 – HHQM-CDF.pdf (Revised)
HHQM10 – HHQM-CTR.pdf (Revised)
HHQM11 – HHQM-FUH.pdf (Revised)
HHQM12 – HHQM-IET.pdf (Revised)
HHQM13 – HHQM-IU.pdf (Revised)
HHQM14 – HHQM-NFU.pdf (Revised)
HHQM15 – HHQM-PCR.pdf (Revised)
HHQM16 – HHQM-PQI92.pdf (Revised)
HHQM17 – HHQM-SSGM.pdf (Revised)
HHQM18 – Hybrid-Data-Source.pdf (Revised)
HHQM19 – Hybrid-or-EHR.pdf (Revised)
HHQM20 – If-Data-Not-Reported.pdf (Revised)
HHQM21 – -Technical-Assistance.pdf (Revised)

Note: With regard to the above designations, "Revised" indicates which templates have been reordered and reformatted.

E. Timeline

At this time, the health home quality measures will not be published but will serve as the official system of record to be used internally to monitor and evaluate the health home benefit.