The Department of Health and Human Services

2015 Annual Report on the Quality of Care for Adults in Medicaid

Health and Human Services Secretary

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), required the Secretary of the U.S. Department of Health and Human Services (HHS) to establish an adult health care quality measurement program to standardize the measurement of health care quality across state Medicaid programs and facilitate the use of the measures for quality improvement. This report, required by Section 1139B of the Social Security Act, as added by Section 2701 of the Affordable Care Act, summarizes information on the quality of health care furnished to adults covered by Medicaid.

In federal fiscal year (FFY) 2014, Medicaid covered a total of 44.3 million adults, including 27.1 million non-elderly adults, 6.3 million adults age 65 and over, and 10.9 million individuals who are blind/disabled.[1] The Centers for Medicare & Medicaid Services (CMS), the HHS agency responsible for ensuring effective health care coverage for Medicaid enrollees, plays a key role in promoting quality health care for adults enrolled in Medicaid. As part of this role, CMS works collaboratively with states to support and encourage reporting and strengthen systems for standardizing reporting on access and quality measures.

This is CMS's second annual report on the quality of care for adults in Medicaid, and the first year that CMS is publicly reporting findings on the core set of health care quality measures for adults enrolled in Medicaid (referred to as the Adult Core Set).[2] This 2015 report presents findings on voluntary state reporting of the Adult Core Set measures for FFY 2014, and summarizes information on managed care quality measurement and improvement reported in the external quality review (EQR) technical reports submitted to CMS by states during the 2014–2015 reporting cycle. Adult Core Set data reported for FFY 2014 generally cover care delivered in calendar year (CY) 2013.

Health insurance coverage—public or private—is critically important for reducing financial barriers in access to quality care. There is considerable evidence that adults covered by Medicaid generally have better access to care than uninsured adults. The landmark Oregon Health Insurance Experiment, a randomized controlled trial that compared the care of Medicaid enrollees selected to be offered coverage with those on a waiting list who were not selected, found Medicaid enrollees had better access to primary care, preventive services, and self-reported physical and mental health.[3] A more recent analysis of data from the 2013 National Health Interview Survey found that non-elderly adults covered by Medicaid were significantly

[1] "2014 CMS Statistics," Table I.16. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. The blind/disabled total includes some children.

[2] The 2014 Secretary's Report is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf.

[3] Finkelstein A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." The Quarterly Journal of Economics, August 2012, vol. 127, no. 3, pp. 1057–106.

more likely than the uninsured to have a usual source of medical care, and to have had a general doctor visit, and a specialty care visit in the past 12 months.[4]

Data Limitations

The legislation that created the adult health care quality measurement program established it as a voluntary reporting program, at the discretion of state Medicaid agencies to participate. In FFY 2014, 34 states[5] voluntarily reported on one or more of the Adult Core Set measures. As such, it is not possible to make national observations of the quality of care provided to adult Medicaid beneficiaries based on data from these 34 states, or based on the smaller number of states that reported on the 10 frequently reported measures for which CMS conducted detailed analysis.[6] This report also does not compare the quality of care for adults covered by Medicaid with that of adults covered through other kinds of health coverage.

This report covers data for the Core Set FFY 2014 reporting period. In most cases, states submitted data for utilization that occurred in calendar year (CY) 2013. In cases in which CY 2013 data were not available, states reported rates for an earlier period.[7] These data therefore do not inform observations about the impact of coverage changes, including the expansion of Medicaid to low-income adults that took effect in 2014. Over the past year, CMS has worked with states to improve the quality and completeness of the data, but some variation remains.

Quality Measurement Using the Adult Core Set

This is the second year of state reporting and the first year that CMS is publicly reporting findings on the Adult Core Set measures. Over the past year, CMS and states achieved significant progress toward CMS's major adult quality reporting goals, including increasing the number of states reporting on the Adult Core Set measures and increasing the use of measures in quality improvement projects.

The number of states voluntarily reporting Adult Core Set measures increased from 30 states for FFY 2013 to 34 states for FFY 2014. While the median number of measures is unchanged at 16.5 measures reported in both years, 31 states reported data on at least half of the 26 Adult Core Set measures for FFY 2014, with two states, Georgia and New York, reporting almost all of the measures (25 and 24, respectively).

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[4] Paradise, J. "Medicaid Moving Forward." Kaiser Family Foundation, March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

[5] The term "states" includes the 50 states and the District of Columbia.

[6] Measure-specific tables for these 10 measures are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Adult-Core-Set-Measures-FFY-2014.zip. See also Table 2 of the report.

[7] Of the 10 frequently reported Adult Core Set measures for FFY 2014, each measure was reported by at least one state using a measurement period that differed from the measure technical specifications.

Thirteen measures were frequently reported for FFY 2014—defined as measures reported by at least 25 states—with the most frequently reported measures focused on diabetes care management, postpartum care visits, and women's preventive health care. CMS conducted detailed analysis of state performance on 10 of these frequently reported measures,[8] with the results (including percentiles, means, medians, trends, and geographic variation) presented in four domain-specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health care.[9]

State Performance on the Adult Core Set

Analysis of performance on the 10 Adult Core Set measures reported by 25 or more states for FFY 2014 provides a snapshot of the quality of care obtained by adults across a continuum of needs. Relative to other measures analyzed in this report, median state performance was fairly high on the three measures of care for acute and chronic conditions (HbA1c test, LDL-C screening test, and monitoring of patients on persistent medications). In addition, performance on the maternity care measure (timeliness of postpartum visit) and the four measures of primary and preventive care (body mass index [BMI] documented in the medical records, and screenings for breast cancer, cervical cancer, and chlamydia), had median rates of 50 percent or higher. Rates of performance on behavioral health measures were lower.

Managed Care External Quality Review Findings

Federal regulations require states to conduct an annual external quality review (EQR) for each contracted managed care organization (MCO) and prepaid inpatient health plan (PIHP). Additionally, the state requires each managed care plan to have an ongoing program of performance improvement projects (PIPs) to improve quality in clinical and nonclinical areas. The results of the EQR and PIPs are summarized in an annual EQR technical report that is available to the public and is submitted to CMS.

Of the 41 states[10] that currently contract with managed care plans, 38 submitted EQR technical reports to CMS for the 2014–2015 reporting cycle.[11] The most frequently reported adult performance measures included in these EQR reports are the same as or similar to those most frequently reported in the Adult Core Set, including measures evaluating adult Medicaid enrollees' behavioral health, diabetes care, and primary care access.

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[8] Three additional measures were reported by at least 25 states, but were not publicly reported for FFY 2014 due to lack of comparable data across states: PQI 01: Diabetes Short-Term Complications Admission Rate; PQI 08: Congestive Heart Failure (CHF) Admission Rate; and PQI 15: Asthma in Younger Adults Admission Rate.

[9] The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip. A fifth domain-specific report focuses on children's use of dental and oral health services in Medicaid and CHIP.

[10] For purposes of EQR technical reports, the term "states" includes the 50 states, the District of Columbia, and the territories.

[11] The 2014–2015 reporting cycle includes reports that were submitted between May 1, 2014 and April 30, 2015. Of the three states that did not submit EQR technical reports in time for the 2014–2015 reporting cycle, two are on target to submit reports by the end of the year, and CMS is monitoring the status of reporting by the third.

Through their managed care entities, states are engaged in various types of improvement projects for adults. For the 2014–2015 reporting cycle, behavioral health and diabetes care were the most common PIP topics among states. While PIP topics, target populations, and interventions and activities were often specific to each managed care entity in a state, 21 states mandated improvement projects on at least one priority health topic. For example, eight states mandated PIPs related to behavioral health.[12] CMS conducted detailed abstractions of reporting on PIPs in four topic areas: (1) diabetes care, (2) hospital readmissions, (3) ED visits, and (4) substance use disorders (SUDs). Analysis of the PIPs indicates that states are using a diverse set of interventions to improve quality of care.

Summary and Conclusion

This report shows the continued progress made by HHS and states in building a national, cross-state voluntary quality measurement and reporting program for adults enrolled in Medicaid. The evolving quality measurement field offers data on performance as a new tool for states to use in driving improvements in care.[13] CMS awarded Adult Medicaid Quality Grants in 2012 to 26 states to develop their capacity to report on the core measures and use that data in quality improvement projects. State efforts focused on topic areas including behavioral health, substance use disorders, and diabetes. In addition, through managed care entities, states continue to advance improvement projects specific to adults in many of these same topic areas, as well as others such as hospital readmissions and cancer screening. In addition, quality improvement initiatives underway in the states and at CMS are aimed at improving health care provided to adults enrolled in Medicaid. In 2014, CMS launched a Maternal and Infant Health Initiative to drive improvements in the care provided during the postpartum period to improve the health outcomes of Medicaid and CHIP enrollees. CMS's Medicaid Innovation Accelerator Program provides program support to states to strengthen care delivery related to substance use disorders, physical/behavioral health integration, community integration using long term services and supports, and Medicaid beneficiaries with complex needs and high costs.

[12] The eight states were Arizona, Florida, Massachusetts, Minnesota, New Hampshire, Oregon, Pennsylvania, and Virginia.

[13] Berwick, D.M., B. James, and M.J. Coye. "Connections Between Quality Measurement and Improvement." Medical Care, vol. 41, no. 1 (Supplement), January 2003, pp. I30–38.

I. INTRODUCTION

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), established the National Quality Strategy for Quality Improvement in Health Care, which serves as the national blueprint to improve the health care delivery system and health outcomes by pursuing three goals: better care, healthy people/healthy communities, and affordable care.[14] These three goals are reflected in the activities undertaken by the Centers for Medicare & Medicaid Services (CMS) and other agencies of the U.S. Department of Health and Human Services (HHS) to improve care for adults enrolled in Medicaid.

Medicaid provided health care coverage to nearly 65 million Americans in federal fiscal year (FFY) 2014, including eligible low-income adults, children, pregnant women, older adults, and people with disabilities. In FFY 2014, Medicaid served 27.1 million non-elderly adults, 6.3 million adults age 65 and over, and 10.9 million individuals who are blind/disabled.[15] Medicaid also provides supplemental coverage for Medicare enrollees (often called dually eligible beneficiaries).

By 2016, an estimated 75 percent of Medicaid enrollees will obtain their care through managed care plans, although the rate of managed care enrollment for adults in Medicaid varies widely across state Medicaid programs.[16] Because of these varying arrangements, a diverse set of quality measurement and improvement efforts are underway across payment and service delivery settings.

The Affordable Care Act required the Secretary of HHS to establish an adult health care quality measurement program to obtain standardized data on the quality of health care across state Medicaid programs. As required by Section 1139B of the Social Security Act, as added by Section 2701 of the Affordable Care Act, this report summarizes FFY 2014 state reporting and performance on the core set of health care quality measures for adults enrolled in Medicaid (referred to as the Adult Core Set) and information collected through external quality reviews (EQRs) of managed care entities.[17,18] This is CMS's second annual report on the quality of care for adults in Medicaid, and the first year that CMS is publicly reporting findings on the Adult

[14] Available at http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2014annlrpt.pdf.

[15] "2014 CMS Statistics," Table I.16. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. The blind/disabled total includes some children.

[16] Avalere Analysis: Medicaid Managed Care Expected to Grow by 13.5 Million (2015) http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli.

[17] For a list of the 2014 Adult Core Set measures, see Supplemental Table AD-1 at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/overview-of-the-adult-core-set-measures-ffy-2014.zip.

[18] Section 1139B(d)(2) of the Social Security Act (42 U.S.C. §1320b-9b(d)(2)). Available at http://www.ssa.gov/OP_Home/ssact/title11/1139B.htm.

Core Set.[19] The 2015 report presents findings on the Adult Core Set measures and summarizes information on managed care quality measurement and improvement reported in the EQR technical reports submitted to CMS by states. This report covers data for the Core Set FFY 2014 reporting period, which generally covers utilization occurring in calendar year (CY) 2013. In some cases, states reported rates for an earlier period if data were not available for CY 2013. As Medicaid expansion became effective on January 1, 2014 for those who signed up, the report does not include specific information or draw conclusions about the effects of the Medicaid expansion on the quality of care for adults enrolled in Medicaid.

[19] The 2014 Secretary's Report is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf.

II. STATE-SPECIFIC FINDINGS ON QUALITY AND ACCESS IN MEDICAID

A. Data Limitations

The legislation that created the adult health care quality measurement program established it as a voluntary reporting program, at the discretion of state Medicaid agencies to participate. In FFY 2014, 34 states voluntarily reported on one or more of the Adult Core Set measures. As such, it is not possible to make national observations of the quality of care provided to adult Medicaid beneficiaries based on data from these 34 states, or based on the smaller number of states that reported on the 10 frequently reported measures for which CMS conducted detailed analysis. This report also does not compare the quality of care for adults covered by Medicaid with that of adults covered through other kinds of health coverage.

This report covers data for the Core Set FFY 2014 reporting period. In most cases, states submitted data for utilization that occurred in calendar year (CY) 2013. In cases in which CY 2013 data were not available, states reported rates for an earlier period. Of the 10 frequently reported Adult Core Set measures for FFY 2014, for example, each measure was reported by at least one state using a measurement period that differed from the measure technical specifications. These data therefore do not inform observations about the impact of coverage changes, including the expansion of Medicaid to low-income adults that took effect in 2014.

States may not always adhere to the measure technical specifications when reporting, making it difficult to compare results from state to state. For example, although the technical specifications for several measures ask states to stratify by two age groups (ages 18 to 64 and age 65 and older), results presented in this report focus on data for enrollees ages 18 to 64. For FFY 2014, CMS chose not to publicly report data separately for Medicaid enrollees age 65 and older, as states varied widely in their use of Medicare data, and without Medicare data, the portrait of care for enrollees age 65 and older would be incomplete. Additionally, the extent to which reported data have been validated is unknown in all states, though CMS is seeking to more consistently obtain this information from states with future reporting.

To improve the quality and completeness of Core Set data, CMS implemented a systematic real-time data review and outreach process for FFY 2014 Core Set data. After reviewing the data, CMS contacted each state to follow up on any concerns about the accuracy or completeness of reported data (such as missing data, transposed values, and inconsistencies in data reported across measures or over time) and also to clarify any aspects of the state's reported populations or methodology that were unclear. As part of this process, CMS also offered states additional technical support with reporting Core Set measures through email and in telephone calls. As a result of this outreach, some states corrected and refined their Core Set data. The corrected data were used to publicly report the data seen in this report. In addition, CMS gained a better understanding of factors that may affect changes in rates reported across years.

With any new reporting program, it may take several years of reporting on the measures before data quality issues like the ones highlighted are resolved. CMS continues to work with states to help improve the accuracy and completeness of the data reported.

B. Quality Measurement Using the Adult Core Set

In FFY 2013 and FFY 2014, states have voluntarily collected and reported data on the Adult Core Set measures. While reporting of a subset of the Adult Core Set measures was required for Adult Medicaid Quality (AMQ) grantee states for FFY 2013 (though states could choose which measures to report), reporting for FFY 2014 was voluntary for all states.[20] Through participation in AMQ quality improvement projects (QIPs) and managed care performance improvement projects (PIPs), states have also continued to engage in initiatives designed to improve the quality of care for adults enrolled in Medicaid.

CMS viewed the first year of reporting of the Adult Core Set as an opportunity to learn and refine the Core Set measures. CMS identified four major goals for the second year of state reporting:

- Increase the number of states reporting on the Adult Core Set measures;
- Increase the number of measures reported by each state;
- Improve the completeness of the data reported; and
- Use the measures as part of state quality improvement initiatives, including for managed care external quality review (EQR) PIPs.

During the past year, CMS and states achieved significant progress toward these goals. Thirty-four states reported one or more of the Adult Core Set measures for the FFY 2014 reporting year, compared to 30 states for FFY 2013 (Table 1 and Figure 1). While the median number of reported measures is unchanged at 16.5 measures reported in both years, altogether, 31 states reported data on at least half, or 13, of the Adult Core Set measures for FFY 2014, up from 28 states for FFY 2013. The states reporting for both years included the 26 AMQ grantees and 4 non-grantee states (Delaware, Illinois, Tennessee, and Virginia). Additionally, four non-grantee states reported at least one Adult Core Set measure for the first time for FFY 2014 (the District of Columbia, Hawaii, Kentucky, and Mississippi). Detailed analysis of state-specific findings is included in four domain-specific reports that provide a snapshot of state performance on 10 Adult Core Set measures reported by at least 25 states.[21]

In January 2012, CMS published the Initial Adult Core Set for voluntary reporting by states.[22] The Affordable Care Act further required that improvements to the core set be issued beginning

[20] Additional information about the Adult Medicaid Quality Grant Program is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grants.html.

[21] Detailed results on state performance on the Adult Core Set measures are presented in four domain-specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health care. A fifth report summarizes children's use of dental and oral health services in Medicaid and CHIP. The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

[22] The Affordable Care Act (Section 1139B) required HHS to identify and publish a core set of health care quality measures for adult Medicaid enrollees for voluntary use by state Medicaid programs. In January 2012, HHS published, an initial core set of 26 measures.

January 2014, and annually thereafter. Part of the process of collecting, reporting, and using the Adult Core Set measures is to establish a way to periodically identify new measures to potentially include in future Adult Core Sets. This process serves several purposes: (1) build upon the original measure set by addressing gap areas; (2) improve upon existing Adult Core Set measures; and (3) better align with national quality measurement activities. The intended result is an Adult Core Set that is more robust and better able to support states' and CMS's quality measurement needs.[23] CMS worked with the National Quality Forum's (NQF's) Measure Applications Partnership (MAP) to conduct an expedited review of the measures in September 2013. After reviewing MAP recommendations and potential updates through CMS's internal measurement review process, CMS issued the 26-measure 2014 Adult Core Set, which removed one measure, Annual HIV/AIDS Medical Visit, and replaced it with the HIV Viral Load Suppression measure.[24] In December 2013, CMS issued an Informational Bulletin detailing updates to the 2014 Adult Core Set.[25]

As with the measures themselves, the data systems and sources used to collect information and monitor progress are also subject to periodic adjustments. CMS has continued making progress toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for the Center for Medicaid and CHIP Services' (CMCS's) quality reporting and performance measurement capacities.

For the 2015 Secretary's Report, CMS conducted the following activities to assess the status of quality measurement, reporting, and improvement efforts by states:

- Reviewed and analyzed findings on the Adult Core Set measures reported to CMS by states for FFY 2014, including analyses of 10 measures reported by at least 25 states;
- Conducted outreach by email and telephone to selected states about the completeness and accuracy of their Adult Core Set data;
- Summarized information on the quality measures and PIPs reported in the EQR technical reports from states that contract with managed care plans to deliver services to Medicaid enrollees (see Chapter III); and
- Prepared detailed analyses of state performance on Adult Core Set measures in four domains: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health care.[26]

[23] Background on the Initial Core Set can be found in a January 2012 Informational Bulletin, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-1-4-2012.pdf.

[24] For a list of the 2014 Adult Core Set measures, see Supplemental Table AD-1 at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/overview-of-the-adult-core-set-measures-ffy-2014.zip.

[25] Updates to the 2014 Adult Core Set are described in a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

[26] The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

C. Changes in State Reporting of the Adult Core Set for FFY 2014

The median number of measures reported by the 34 states reporting for FFY 2014 remains unchanged from FFY 2013 at 16.5 measures. Altogether, 31 states reported data on at least half, or 13, of the Adult Core Set measures for FFY 2014 (Figure 1), up from 28 states for FFY 2013. Seven states reported on 21 or more Adult Core Set measures for FFY 2014, including one state, Georgia, which reported on 25 measures. This demonstrates improvement over the past year, when five states reported on 21 or more measures for FFY 2013. Fifteen states reported more measures for FFY 2014 than FFY 2013. Seven states reported the same number of measures, and 12 states reported fewer measures for FFY 2014 than FFY 2013.

Altogether, 13 Adult Core Set measures were reported by at least 25 states for FFY 2014, 10 of which are being publicly reported (Figure 2).[27] The five measures reported most frequently by states are part of the Healthcare Effectiveness Data and Information Set (HEDIS®), and are often included in Medicaid managed care contracts for monitoring the quality of care provided to Medicaid enrollees receiving care through managed care entities.[28] In addition, these measures are calculated primarily using Medicaid administrative data and do not require medical record review. In FFY 2014, the five most frequently reported measures were:

- Comprehensive Diabetes Care: Hemoglobin A1c Testing: 34 states reporting
- Comprehensive Diabetes Care: LDL-C Screening: 34 states reporting
- Postpartum Care Rate: 34 states reporting
- Cervical Cancer Screening: 33 states reporting
- Chlamydia Screening in Women: 32 states reporting

The majority of the Adult Core Set measures (20 measures) saw an increase in the number of states reporting data for FFY 2014 (Figure 3). The measures with the largest increase from FFY 2013 to FFY 2014 in the number of states reporting were:

- Adult Body Mass Index (BMI) Assessment: increased from 16 to 26 states reporting
- Chlamydia Screening in Women: increased from 26 to 32 states reporting
- Antidepressant Medication Management: increased from 25 to 31 states reporting
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: increased from 18 to 24 states reporting

[27] For a measure to be publicly reported, data must be provided to CMS by at least 25 states and meet internal standards for quality. Three measures (PQI-01, PQI-08, and PQI-15) were reported by at least 25 states, but are not publicly reported this year due to data quality issues that CMS is actively working to address in collaboration with states.

[28] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The least frequently reported measures in the 2014 Adult Core Set require states to conduct medical record reviews to collect the necessary data, which is a resource-intensive process for states. Reasons for not reporting vary by state, but the medical record review requirement, data availability, and data access are among the most frequently cited reasons for not reporting. Through the Quality Measures Technical Assistance and Analytic Support (TA/AS) Program,[29] CMS will continue to work with states to support state capacity for reporting.

D. Summary of Key Findings

The increase in the number of states reporting Adult Core Set measures—from 30 states for FFY 2013 to 34 states for FFY 2014—enabled CMS to conduct deeper analysis on the most frequently reported measures this year. Although the technical specifications for several measures ask states to stratify by two age groups (ages 18 to 64 and age 65 and older), results presented in this report focus on data for enrollees ages 18 to 64.[30] This section summarizes CMS's analysis of state performance on 10 measures across four domains: (1) primary care access and preventive care, (2) maternal and perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health.[31]

1. Primary Care Access and Preventive Care

Four measures of primary care access and preventive care—Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, and Adult Body Mass Index (BMI) Assessment—were available for analysis for FFY 2014.

The frequency of breast and cervical cancer screenings is an indicator of the preventive care services provided to women enrolled in Medicaid. For FFY 2014, the median rates were 53 percent for breast cancer screening (31 states reporting), and 58 percent for cervical cancer screening (33 states reporting) (Table 2). Chlamydia screening also plays a critical role in promoting women's health. Left untreated, chlamydia can affect a woman's ability to have children. The median rate was 59 percent of sexually active women ages 21 to 24 who received the recommended chlamydia screening (32 states reporting).

Monitoring of BMI helps providers identify adults at risk for becoming overweight or obese. The Adult BMI Assessment measure indicates the percentage of adults with a primary care visit

[29] The TA/AS Program is led by Mathematica Policy Research in collaboration with National Committee for Quality Assurance (NCQA) and Center for Health Care Strategies (CHCS), and supports reporting of CMCS Medicaid/CHIP quality measures, including the Adult, Child, and Health Homes Core Sets, and Maternal and Infant Health Initiative measures. More information about the TA/AS Program is available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/tafactsheet.pdf.

[30] For FFY 2014, CMS chose not to publicly report data separately for Medicaid enrollees age 65 and older. States varied widely in their use of Medicare data, and without Medicare data, the portrait of care for enrollees age 65 and older would be incomplete.

[31] Additional information on state performance, including percentiles and geographic variation, is available in domain-specific reports, along with companion measures from the Child Core Set. The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

whose BMI value was documented in the medical record. About two-thirds of adults with a primary care visit in the past year had their BMI value documented in the medical record (the median was 69 percent among 26 states reporting for FFY 2014).

For more information on the Primary Care Access and Preventive Care measures, see the Primary Care Access and Preventative Care domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

2. Maternal and Perinatal Health

In 2010, Medicaid financed nearly half of all births in the United States, ranging from a low of 24 percent of all births in Hawaii to a high of 69 percent of births in Louisiana.[32] Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes and hypertension), mental health status (including postpartum depression), and family planning (including contraception and inter-conception counseling). CMS's Maternal and Infant Health Initiative aims to increase the postpartum care rate among women enrolled in Medicaid.[33]

The Postpartum Care Rate measure assesses how often Medicaid enrollees received timely postpartum care (between 21 and 56 days after delivery). Among the 34 states reporting for FFY 2014, a median of 58 percent of women covered by Medicaid/CHIP had a postpartum visit between 21 and 56 days after delivery (Table 2).

For more information on the Maternal and Perinatal Health measures, as well as the CMS initiatives underway to improve perinatal care, see the Perinatal Care domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

3. Care of Acute and Chronic Conditions

Visits for routine screening and monitoring play an important role in managing the health care needs of people with acute and chronic conditions, potentially avoiding or slowing disease progression, and reducing costly hospital admissions and ED visits. Three Adult Core Set measures of the Care of Acute and Chronic Conditions—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Test, Comprehensive Diabetes Care: LDL-C Test, and Annual Monitoring for Patients on Persistent Medications—were available for analysis for FFY 2014. Two of these measures assess whether Medicaid enrollees had routine monitoring for diabetes care (type 1 or type 2), while the third assesses monitoring for medication treatments including angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), digoxin, or diuretics.

[32] Markus, A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues, vol. 23, no. 5, pp. e273–e280.

[33] More information about CMS's Maternal and Infant Health Initiative is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care-quality.html. The Initiative aims to increase by 10 percentage points the rate of postpartum visits among women in Medicaid and CHIP in at least 20 states over a 3-year period.

Overall, performance by the states reporting on the three measures was relatively high. A median of 80 percent of Medicaid enrollees with diabetes had an HbA1c test during the year and a median of 68 percent of enrollees had an LDL-C screening test during the year among the 34 states reporting the two measures (Table 2). In addition, the vast majority of adult Medicaid enrollees who received ambulatory medication therapy for a select therapeutic agent for at least 180 treatment days had routine monitoring for the medication during the year. Among the 27 states reporting the Annual Monitoring for Patients on Persistent Medications measure, the state median was 85 percent.

For more information on the Care of Acute and Chronic Conditions measures, see the Care of Acute and Chronic Conditions domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

4. Behavioral Health Care

As the single largest payer for mental health services in the United States, Medicaid plays an important role in providing behavioral health care to adults, and monitoring the effectiveness of that care. Two measures of behavioral health care—Follow-Up After Hospitalization for Mental Illness and Antidepressant Medication Management—were available for analysis for FFY 2014.

Follow-up care after hospitalization for mental illness helps improve health outcomes and prevent readmissions in the days following discharge from inpatient mental health treatment. For FFY 2014, 30 states reported a median rate of 37 percent for follow-up visits within seven days of discharge and 57 percent for follow-up visits within 30 days of discharge (Table 2).

The effective use of antidepressants is an important standard of care for patients receiving treatment for depression. When individuals are first diagnosed with major depression, medication may be prescribed either alone or in combination with psychotherapy. An initial course of medication treatment is recommended for 12 weeks to choose an effective regimen and observe a clinical response. Continued treatment for six months is recommended to prevent relapse and to maintain functioning. Among the 31 states reporting the Antidepressant Medication Management measure for FFY 2014, the median rates were 47 percent of Medicaid enrollees who were treated with antidepressant medication for 12 weeks, and 31 percent who were treated with medication for six months.

These results suggest that states have substantial room for improvement on the two behavioral health care measures, and suggest there is a need for enhanced integration of physical and behavioral health care and more coordination across multiple settings of care.

For more information on the Behavioral Health Care measures, see the Behavioral Health Care domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

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III. MONITORING AND IMPROVING CARE FOR ADULTS ENROLLED IN MANAGED CARE

In 2011, 62 percent of adults ages 21 to 64 enrolled in Medicaid obtained their health care through managed care plans. The rate of managed care enrollment for adults in Medicaid varied widely across state Medicaid programs, ranging from less than 10 percent of enrollees in 18 states to more than 90 percent in Delaware, Hawaii, and Tennessee.[34] Regardless of the enrollment rate, states using a managed care delivery system must comply with certain federal requirements, including standards to assess and monitor the quality of care provided by contracted managed care plans. This chapter summarizes state activities related to monitoring and improving care for adults in managed care.[35]

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states that elect to use managed care for the delivery of health care in Medicaid.[36] Federal regulations implemented in 2003 require states to perform an annual external quality review (EQR) for each contracted managed care organization (MCO), prepaid inpatient health plan (PIHP), and health insuring organization (HIO).[37] These annual EQRs analyze and evaluate information on the quality, timeliness, and access to the health care services that an MCO or PIHP, and their contractors, furnish to Medicaid beneficiaries. Section 1139B(d) of the Social Security Act, as amended by section 2701 of the Affordable Care Act, requires the HHS Secretary to include in this annual report information that states collect through EQRs.[38]

Federal managed care regulations at 42 CFR 438.310 et seq. lay out the parameters for conducting an EQR, including state responsibilities, qualifications of an external quality review organization (EQRO), federal financial participation, and state deliverable requirements. Per regulation, the state, its agent (that is not an MCO or PIHP), or an EQRO must perform three

[34] Mathematica analysis of 2011 Medicaid Analytic eXtract data from 45 states. Because MAX 2011 data are unavailable for Arizona, Colorado, the District of Columbia, Hawaii, Idaho, and Louisiana, MAX 2010 data were used. Includes full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only).

[35] Information about the EQR process is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[36] Codified at Section 1932(c) of the Social Security Act.

[37] See 42 CFR 438.2 for full definitions of MCO, PIHP, and HIO. HIOs are treated as MCOs for purposes of this analysis.

[38] Section 1139B(d) of the Social Security Act also requires the reporting of state-specific information on the quality of health care furnished to adults in benchmark plans under Section 1937 of the Act. There are currently no separate state reporting requirements for benchmark plans other than the EQR reporting process required for states contracting with MCOs and PIHPs. In other words, state EQR technical reports must include information related to benchmark plans that deliver care through MCOs or PIHPs; however, because this information is reported in the aggregate, which is allowable under EQR requirements, detailed data are not available for benchmark plans.

EQR-related activities: (1) validation[39] of performance measures; [40] (2) validation of performance improvement projects (PIPs);[41] and (3) a review, at least every three years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement.[42] The state also may choose to perform additional EQR-related activities.[43]

The state must contract with a qualified EQRO to produce an annual technical report that uses information from the EQR-related activities to assess the quality, timeliness, and access to care provided by each MCO and PIHP. Per regulation, the EQR technical report is a public document, available upon request to all interested parties.[44]

B. External Quality Review Technical Reports Submitted to CMS, 2014–2015 Reporting Cycle

Of the 41 states[45] that contracted with MCOs or PIHPs during the 2014–2015 reporting cycle,[46] 38 states submitted EQR technical reports to CMS.[47] These states contracted with 15 different EQROs to conduct the annual EQR, and five EQROs conducted reviews for multiple states during the 2014–2015 reporting cycle.[48] The majority of EQR technical reports focused on

[39] 42 CFR 438.320 defines validation as the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

[40] In accordance with 42 CFR 438.240(c), managed care states must require each MCO and PIHP to annually measure and report to the state its performance using standard measures required by the state. States are then required to annually ensure that performance measures reported by the MCO or PIHP during the preceding 12 months are validated.

[41] In accordance with 42 CFR 438.240(d), managed care states must require each MCO and PIHP to have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. States are then required to annually ensure that any MCO or PIHP performance improvement projects underway during the preceding 12 months are validated.

[42] 42 CFR §438.358(b)(3).

[43] Refer to 42 CFR 438.358(c) for a comprehensive list of optional EQR-related activities.

[44] See 42 C.F.R. § 438.364.

[45] For purposes of EQR technical reviews, the term "states" includes the 50 states, the District of Columbia, and the territories.

[46] The 2014–2015 reporting cycle includes reports that were submitted between May 1, 2014 and April 30, 2015.

[47] Of the 41 states that contracted with MCOs or PIHPs, three (Indiana, Puerto Rico, and Texas) did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis, and one (Delaware) submitted readiness reviews only. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2014–2015 reporting cycle; therefore, North Dakota's EQR technical report is not included in this analysis. Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll adults covered by Medicaid. While Vermont is required to conduct an EQR under the terms of its Section 1115 demonstration, its managed care entity is neither an MCO nor a PHIP and therefore is excluded from this analysis.

[48] For a list of EQROs with current state Medicaid contracts in 2014, see EQR Table AD-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

physical health services, but some included information on other types of managed care services, such as long-term services and supports (LTSS) or behavioral health.

The 2014–2015 EQR technical reports provide insight into the strategies and efforts that states use to improve the quality of care for adults in Medicaid. This report profiles quality measurement and improvement efforts underway related to adults enrolled in Medicaid managed care entities. The EQR technical reports indicate that states and managed care entities engage in a variety of quality measurement and improvement efforts. Generally, the scope and focus of state initiatives are based on several factors, including the populations served by managed care, stakeholder and beneficiary feedback, and clinical areas in need of improvement.

The structure, level of detail, and focus on quality, access, and timeliness of care varied considerably depending on the EQR technical report. For example, some EQR technical reports did not explicitly discuss quality, access, and timeliness at all, while others provided substantial detail related to the performance measure and PIP validation process, PIP interventions, and performance outcomes. This lack of uniformity across EQR technical reports is due to differences in state interpretation of regulatory language. While regulations require states to validate performance measures and PIPs annually, they do not specifically require the inclusion of details on outcomes or interventions in the EQR technical reports.

C. Performance Measures, 2014–2015 Reporting Cycle

In the 2014–2015 reporting cycle, the most frequently reported performance measures for adults focused on behavioral health (reported by 29 states),[49] diabetes care (27 states), cancer screening (25 states), asthma/Chronic Obstructive Pulmonary Disease (COPD) (24 states), access to primary care (24 states), and cardiac care (22 states).[50] The reported performance measures showed considerable overlap with both the CMS Adult Core Set and the HEDIS 2014 measures, though the use of these measure sets is not required by CMS. Additionally:

- Of the 37 states that submitted EQR technical reports for the 2014–2015 reporting cycle for managed care plans that cover adults, 35 identified the topic or focus of performance measures reported by MCOs and PIHPs, and 34 identified the performance measures validated by the EQRO.[51]

[49] Behavioral health is defined broadly to include tobacco cessation and treatment of mental health and substance use disorders (SUDs) including alcohol and other drugs.

[50] See EQR Figure AD-1 for information about the number of states reporting performance measures in each topic area. More detailed information related to state reported performance measures for adults can be found on EQR Table AD-3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[51] This analysis focuses on the 37 states that submitted EQR technical reports for the 2014–2015 reporting cycle for managed care plans that cover adults. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2014–2015 reporting cycle; therefore, North Dakota's EQR technical report is not included in this analysis.

- 31 states included the performance rates achieved by each MCO or PIHP.[52] Of these:
  - 27 states compared MCO and PIHP performance to national HEDIS Medicaid rates.
  - 24 states compared performance in the 2014–2015 reporting cycle to performance in previous years.
  - 23 states compared individual MCO and PIHP performance rates to statewide managed care performance rates.
  - 17 states included comparisons to state target rates.
  - 14 states reported performance rates for specific subpopulations within the state. For example, Arizona, Florida, and New York included performance rates by geographic region, while Georgia reported results by delivery system (managed care versus fee-for-service).

The most commonly reported performance measures for this reporting cycle are consistent with those reported in the previous reporting cycle (Figure 4). Among the 33 states that reported performance measures in both reporting cycles, the most notable changes were the increases in the number of states reporting cancer screening measures (an increase of 9 states), primary care access measures (increase of 7 states), and behavioral health measures (increase of 6 states).

D. Performance Improvement Projects, 2014–2015 Reporting Cycle

Of the 37 states that submitted EQR technical reports for the 2014–2015 reporting cycle for managed care plans that cover adults, 34 included at least one PIP that targeted adults, and all of those states provided information on the results of the review process in the EQR report, as required by regulation (Table 3). States often deferred to the MCO or PIHP to propose and implement topics and interventions; however, 21 states mandated at least one specific PIP topic or required participation in a collaborative project focused on adults.[53] For example, eight states (Arizona, Florida, Massachusetts, Minnesota, New Hampshire, Oregon, Pennsylvania, and Virginia) mandated that managed care entities in the state conduct PIPs related to behavioral health. Other state-mandated PIP topics included: asthma/COPD, care transitions, colorectal cancer screening, diabetes care, ED visits, and hospital readmissions.

The topical focus and number of PIPs varied considerably among the 34 states that included at least one PIP that targeted adults (Table 3).

[52] See EQR Table AD-4 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[53] States that mandated PIP topics for MCOs or PIHPs include: Arizona, California, Florida, Georgia, Hawaii, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, and West Virginia.

- Most states conducted 20 or fewer PIPs targeting adults, while eight states had more than 20 PIPs. Florida, Minnesota, and Oregon conducted the largest number of PIPs: 87, 51, and 49 PIPs, respectively. In many states, particularly in those that mandated PIPs on specific topics, the PIPs in the state focused on a small number of priority health topics. For example, in Arizona almost all of the PIPs in the state focused on reducing preventable hospital readmissions. States that required each of their managed care entities to conduct multiple PIPs and allowed them to choose at least one topic, reported a wider variety of topics. Minnesota required health plans to conduct PIPs focused on behavioral health, cancer screening, and diabetes care. In addition, plans in the state also conducted PIPs focused on COPD, care transitions, reducing ED visits, and reducing hospital readmissions, resulting in a wide range of improvement projects in the state.
- Behavioral health and diabetes were the most common PIP topics for the 2014–2015 reporting cycle (20 states reported PIPs related to each of these topics).
- Other common PIP topics included hospital readmissions (15 states and 91 PIPs), ED visits (12 states and 34 PIPs), and cancer screening (11 states and 35 PIPs).

Among the 32 states that submitted EQR technical reports during both the 2013–2014 and 2014–2015 reporting cycles, the total number of states conducting PIPs focused on asthma/COPD, behavioral health, cancer screening, cardiac care, diabetes, hospital readmissions, and weight/BMI increased from the previous reporting cycle (Figure 5). The increased focus on quality improvement efforts in these topic areas may reflect changing health care needs or priorities within the states.

Discussions of EQRO findings on the performance, progress, and limitations of each PIP differed greatly across reports, with descriptions of PIPs occasionally lacking key details. This lack of detailed intervention and outcomes information within the EQR technical reports has limited CMS's ability to conduct a comprehensive assessment on the efficacy of state quality improvement efforts for children and pregnant women enrolled in managed care. However, the level of detail presented in the EQR technical reports has become more comprehensive over the past few years, following intensive CMS outreach and technical assistance efforts.

E. Review of Performance Improvement Projects

The following section presents findings from detailed abstractions of EQRO reporting on PIPs in four health topic areas: (1) diabetes care, (2) hospital readmissions, (3) ED visits, and (4) treatment of substance use disorders.[54] An example of a state improvement project is highlighted for each topic area. Criteria for selecting states to highlight included geographic diversity across reporting years and across PIP topics, the EQR validation rating,[55] and the

[54] Additional information on "Findings from EQR Technical Reports, 2014–2015" is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[55] Use of the term "validation" differed across EQR reports. The state examples all based the validation rating on the EQR Protocol 3: Validating Performance Improvement Projects (PIPS): A Mandatory Protocol for External

amount of information related to interventions and outcomes included in the EQR technical reports.

1. Diabetes Care

Twenty states reported a combined total of 101 PIPs on adult diabetes during this reporting cycle (Table 3). In seven states (Georgia, Hawaii, Kansas, Minnesota, Nevada, Ohio, and Oregon), diabetes PIPs were mandated for all health plans. While the PIP interventions varied across states and health plans, common improvement aims included: controlling HbA1c (a measure of blood sugar), managing LDL-C (a measure of cholesterol), managing blood pressure, increasing the percentage of members who had a diabetic retinal eye exam, and improving medication management.

All seven MCOs in Hawaii operated PIPs aimed at improving care for members with diabetes. In the 2014–2015 reporting cycle, the PIPs were in different stages of implementation; two MCOs reported baseline data, three MCOs had progressed to the first year of results, one MCO was in the third year of results, and one MCO was in the fourth year of results. The study indicators that the MCOs used to assess performance differed slightly across plans, and included the percentage of members with diabetes (type 1 and type 2) who had: (1) an eye screening for diabetic retinal disease, (2) a blood pressure reading with the most recent reading being <140/90mmHg, (3) an HbA1c test with the most recent results being <8 percent, and (4) an LDL-C test with the most recent results being <100mg/dL. Baseline performance on these indicators ranged considerably by indicator and by MCO. For example, baseline rates on the LDL-C screening indicator ranged from 24 percent of members in one MCO to 79 percent of members in two MCOs. Each MCO set its own goals for each study indicator, most commonly targeted to the HEDIS 50th and 75th percentiles for the year.

Based on positive results from PIP interventions in previous years, most of the MCOs continued member and provider outreach and education activities that they had implemented prior to the 2014–2015 reporting cycle. For example, most MCOs continued to provide materials on diabetes care to members to increase their awareness of disease management programs. The MCOs also continued to focus on provider activities such as pay-for-performance programs and distribution of HEDIS toolkits. During this reporting cycle, the MCOs also implemented new member-outreach interventions including targeted outreach to members with gaps in care, using service coordinators to improve member compliance with disease management guidance (such as refilling and picking up medications and completing recommended appointments with physicians), providing free eye exams from a van that traveled to areas with need for additional services, and enrolling members in patient-centered medical homes. New interventions targeted

(continued)

Quality Review (EQR), Version 2.0, September 2012. The protocol details the following 10 activities: (1) select the study topic; (2) define the study question(s); (3) select the study indicators; (4) use a representative and generalizable study population; (5) use sound sampling techniques (if sampling was used); (6) reliably collect data; (7) analyze and interpret study results; (8) implement intervention and improvement strategies; (9) assess for real improvement; and (10) assess for sustained improvement. Each EQRO calculated the percentage score of evaluation elements met by each MCO to determine a status of met, partially met, or not met.

at providers included efforts to improve disease management collaboration across different types of providers and targeted resources for providers to identify patients who had gaps in care.

All seven MCOs met EQRO validation criteria for the 2014–2015 reporting cycle. Overall, greater performance improvements were achieved by the PIPs in their third and fourth years than by the PIPs reporting their first year of results. The MCO reporting its fourth year of results had relatively high performance on all three of its study indicators at baseline and reported improvements on all three indicators in this reporting cycle, with two increases being statistically significant. The MCO reported statistically significant increases on the HbA1c indicator (from 83 percent at baseline to 88 percent in this reporting cycle) and the retinal eye exam indicator (from 43 percent to 64 percent), and an increase that was not statistically significant on the LDL-C screening indicator (from 79 percent to 83 percent). Although results were more mixed in the MCOs reporting their first year of results, there were some improvements among these PIPs as well. For example, one MCO reported a statistically significant increase in the LDL-C indicator, from 56 percent at baseline to 66 percent in the first year of results, exceeding the MCO's goal.

2. Hospital Readmissions

Fifteen states reported a combined total of 91 PIPs aimed at reducing preventable hospital readmissions during this reporting cycle (Table 3). Seven states (Arizona, California, Hawaii, Illinois, Massachusetts, Pennsylvania, and Washington) mandated PIPs targeting hospital readmissions for all health plans. Interventions often focused on implementing discharge planning and transitional care activities, such as appointment reminder calls and mailings after discharge, to ensure members' post-discharge needs were met.

Pennsylvania required all eight of its MCOs to implement a PIP aimed at decreasing the percentage of inpatient acute care discharges with subsequent readmission to inpatient acute care within 30 days of discharge.[56] In their PIP documentation, the MCOs stated that hospital readmissions are costly, potentially harmful to the patient, and often avoidable. In developing their PIPs, the MCOs reviewed the factors associated with readmissions, such as poor discharge procedures, poor coordination of services, incomplete discharge care, and inadequate follow-up care. To address these issues, the MCOs implemented member, provider, and system-level interventions. Examples of member-level activities include: (1) calling members with special needs who would benefit from a case management evaluation and (2) performing case management outreach and follow-up with discharged members for coordination of care. Examples of provider-level activities include: (1) contacting primary care providers to notify them of a member's hospitalization, (2) conducting outreach to providers to discuss case management for members with frequent inpatient events, and (3) delivering Evidence-Based Quality Guideline Toolkits to high-volume practices. Examples of system-level activities include: (1) enhancing case management by meeting beneficiaries in their communities, (2) conducting daily reviews of admission reports and member discharge plans, (3) increasing

[56] Pennsylvania also required its five behavioral health plans to implement PIPs that aimed to reduce the percentage of members who were discharged from acute inpatient psychiatric facilities to an ambulatory setting who were readmitted within 30 days without a substance use disorder diagnosis. These PIPs were in the implementation stages in the 2014–2015 reporting cycle and results were not yet available.

collaboration with behavioral health MCOs, (4) adding embedded nurses and case managers in targeted hospitals, and (5) supporting the Medicaid Asthma Condition Management Program.

The MCOs assessed their performance on each of the study indicators at six-month intervals, including analyzing results by subpopulation of enrollees (based on demographic factors such as race, ethnicity, and age as well as differences across hospitals) to determine progress and identify areas for targeted interventions. For example, after assessing interim results, one MCO eliminated the requirement for home health care authorization for the member's first six visits to address the burden of obtaining authorization by providers and discharge planners. In the second results measurement period, six of Pennsylvania's eight MCOs succeeded in decreasing their rate of inpatient acute care readmissions from their baseline rates. Readmission rates at baseline differed considerably across plans and limited direct comparison of PIP results. For example, 30-day readmissions rates at baseline ranged from a low of 4.4 percent to 31.3 percent across MCO. In the remeasurement period, the MCOs reported decreasing their admission rates between 1.3 and 9.4 percentage points. The MCO with the highest rate at baseline had the greatest rate reduction, reporting a post-intervention rate of 21.9 (a reduction of 9.4 percentage points). The MCO with the lowest rate at baseline reported a smaller decline of 1.4 percentage points, but achieved a readmission rate of 3.0 percent, maintaining the lowest rate in the state. The two MCOs that reported increased readmission rates both reported increases of less than one percentage point over their baseline rate. The EQRO noted that interventions that drive systems changes, pay structure changes, and case management targeting groups most in need will help drive improvements and encouraged the MCOs to continue to move toward these types of interventions to make additional progress, rather than focusing on broader educational interventions.

3. Emergency Department Visits

Twelve states reported a combined total of 34 PIPs focused on reducing inappropriate ED use during this reporting cycle (Table 3). The mostly frequently reported improvement aims in this area were reducing the rate of avoidable ED utilization and increasing the rate of ED visits that do not result in an inpatient stay. PIP interventions most commonly focused on outreach and education to providers and members to encourage greater use of primary and preventive care services.

Beginning in the 2013–2014 reporting cycle, Louisiana required all four of its MCOs to conduct PIPs aimed at decreasing ED utilization. All MCOs used the HEDIS Ambulatory Care: ED Visits measure as the target indicator but they developed their own performance goals for the 2014–2015 reporting cycle. For example, three MCOs aimed to reduce their ED visit rate to meet or exceed the Medicaid HEDIS 50th percentile. Another MCO aimed to reduce ED visits for diabetes, asthma, and cardiac disease by 3 percent. One MCO also tracked the percentage of ED visits that were made by "frequent fliers," or individuals with high rates of ED use. To reduce ED visit rates, the MCOs implemented a variety of interventions aimed at both members and providers. Interventions targeted to members included: targeted mailing of educational materials, outreach to encourage use of primary care medical homes, telephonic outreach to members, and home visits conducted by the Community Education Department.

Provider interventions across the four MCOs included providing ED utilization data to providers, compensating providers for after-hours services, distributing provider report cards, and educating interns and residents about appropriate use of the ED. Three of the four MCOs also implemented system-level interventions, including implementing an ER Coach pilot project, establishing a 24/7 nurse hotline, promoting primary care medical home accreditation, expanding contracts with urgent care centers, and assigning care managers to high-volume EDs.

Louisiana's EQR technical report included different levels of detail about the baseline and post-intervention rates for each MCO, precluding overall assessments of PIP performance in the state. Baseline and results data were available for two MCOs and both of these MCOs achieved reductions in ED visit use. One MCO achieved its goal of exceeding the HEDIS 50th percentile of 63.15 visits per 1,000 member months (with the rate decreasing from 64.1 at baseline to 58.7 at remeasurement). In the other MCO with sufficient data, the decline was slight (from a rate of 74.9 at baseline to 74.0 at remeasurement). To achieve greater reductions in ED visit rates the EQRO recommended that the MCOs add or enhance targeted interventions to individuals with certain chronic conditions (such as asthma and sickle cell) as well as individuals who continue to be high ED utilizers.

4. Substance Use Disorders

Within the broader category of behavioral health, nine states (Arizona, California, Hawaii, Kansas, Massachusetts, Oregon, Tennessee, Utah, and Wisconsin) reported one or more PIPs specifically focused on substance use disorders, for a combined total of 38 PIPs on SUDs. Substance use disorder PIPs include those that focus on treatments to reduce the use of alcohol, tobacco, and other drugs.

Since 2011, Massachusetts has required all five of its MCOs to participate in a PIP to determine whether the receipt of aftercare services following discharge from an acute inpatient treatment services facility for substance use results in a lower percentage of members readmitted to an inpatient facility. The state cited research indicating that patients who participate in aftercare following detoxification have better outcomes regarding drug abstinence and detoxification readmission. In addition to plan-specific interventions, all five MCOs implemented the Community Support Program Specialty Model of Care, which connects members who are being discharged from detoxification programs with a community-based team of providers. These services are designed to respond to the needs of members whose pattern of service utilization indicates a high risk of readmission to 24-hour treatment facilities, and they are structured to support individuals who are not able to independently navigate access and sustain involvement with needed services.

The MCOs used different performance measures to assess their progress on the PIP. As a result, the results are not directly comparable across MCOs, though they appear to indicate mixed success in reducing readmission rates. However, the EQRO noted that in all PIPs the readmission rates for members who received aftercare were lower than the rates for members who did not receive these services.

- Three MCOs compared readmission within 30 days for members ages 13 to 64 who received aftercare services to rates for members who did not receive aftercare services. Two of these MCOs reduced readmission rates from baseline for members who received aftercare services. One reduced its rate by 2.1 percentage points (to a rate of 14.5 percent); the second reduced its rate by 5.5 percentage points (to a rate of 10.8 percent). The third MCO reported an increase in readmissions of less than 1 percentage point (to a remeasurement rate of 16.3) among members who received aftercare. The MCO that reported increased readmissions redesigned its aftercare program following its initial results. The purpose of the redesign was to increase member engagement and included both telephonic and community-based services to members based on their identified needs and preference.
- The fourth MCO also compared readmission rates for members with and without aftercare; however, the MCO focused on the 90-day readmission rate among members ages 19 to 64. This MCO reported an increased readmission rate, from 26.3 percent at baseline to 30.7 percent at remeasurement. The EQR report indicated that the MCO continued to refine its interventions to support its effort to reduce readmission rates.
- The remaining MCO assessed 30-day readmission rates for all members and did not distinguish between those who received aftercare and those who did not. The MCO reported an increased readmission rate (from 22 to 29 percent). Following this decline in performance, the MCO enhanced efforts to coordinate care among providers following inpatient discharges and increased its outreach to low-performing providers. The EQRO suggested that the MCO add interventions that were more focused on members.

IV. SUMMARY AND CONCLUSION

This report shows the progress made by HHS and states in building a national, cross-state quality measurement and reporting program for adults enrolled in Medicaid. This report covers data for the Adult Core Set FFY 2014 reporting period, which generally covers utilization occurring in calendar year (CY) 2013. In cases in which CY 2013 data was not available, states reported rates for an earlier period.[57] As Medicaid expansion became effective on January 1, 2014 for those who signed up, the report does not include specific information or draw conclusions about the effects of the Medicaid expansion on the quality of care for adults enrolled in Medicaid. During the second year of reporting on the Adult Core Set, the number of states voluntarily reporting measures increased from 30 states for FFY 2013 to 34 states for FFY 2014. States reported a median of 16.5 measures for FFY 2014.

Analysis of performance on the 10 Adult Core Set measures reported by 25 or more states for FFY 2014 provides a snapshot of the quality of care obtained by adults across a continuum of needs. States had relatively high performance on the three measures of care for acute and chronic conditions (HbA1c test, LDL-C screening test, and monitoring of patients on persistent medications); the median rates ranged from 68 to 85 percent. Performance on three measures of preventive care and one on maternity care was mixed, with median rates of slightly more than half of women receiving recommended screenings (for breast cancer, cervical cancer, and chlamydia), two-thirds of adults had their BMI documented in the medical records, and three-fifths of women who gave birth had a postpartum visit during the recommended time period (21 to 56 days after delivery). Findings on the two behavioral health measures (follow-up after hospitalization for mental illness and antidepressant medication management) highlight the need for improvement in the care of enrollees with mental health problems (on three of the four rates that comprise these two measures, medians were below 50 percent across the states reporting the measures). The review of improvement projects summarized in the EQR technical reports identified state-initiated efforts underway to assess and improve the quality of care for adults in Medicaid managed care. During the 2014–2015 reporting cycle, the most common improvement topic area was behavioral health (including substance use disorders), a focus that is consistent with findings on state performance on the Adult Core Set measures, which highlighted the need for improvements in the quality of care for adults with behavioral health diagnoses.

Health insurance coverage—public or private—is critically important for reducing financial barriers in access to quality care. While there is considerable evidence that adults covered by Medicaid generally have better access to care than uninsured adults, there is more limited research and mixed results when comparing access and quality of care among low-income adults with health coverage. The landmark Oregon Health Insurance Experiment found Medicaid enrollees had better access to primary care, preventive services, and self-reported physical and mental health relative to the control group.[58] A more recent analysis found that non-elderly

[57] Of the 10 frequently reported Adult Core Set measures for FFY 2014, each measure was reported by at least one state using a measurement period that differed from the measure technical specifications.

[58] Finkelstein A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." The Quarterly Journal of Economics, August 2012, vol. 127, no. 3, pp. 1057–106.

adults covered by Medicaid were significantly more likely than the uninsured to have a usual source of medical care, and to have had a general doctor visit, and a specialty care visit in the past 12 months.[59] The limited research comparing access and quality of care among low-income adults with health coverage shows more mixed results. For example, data from two nationally representative surveys provide evidence that individuals covered by Medicaid have rates of access that are comparable to those of individuals with job-based coverage. One study, analyzing data from the 2013 National Health Interview Survey, found that when controlling for differences in demographics, health status, and socioeconomic factors, the percentage of nonelderly adults with a doctor visit or specialty care visit in the past year were not significantly different between Medicaid and job-based coverage, though the percentage of nonelderly adults with a usual source of care was slightly higher for those with job-based versus Medicaid coverage.[60] Similar findings were reported in an analysis of low-income adults using data from the 2003–2009 Medical Expenditure Panel Survey.[61] In contrast, an assessment that compared low-income adults covered by Medicaid to privately-insured adults (irrespective of their income) found that privately-insured adults had better access than adults covered by Medicaid on five (63 percent) of eight measures, but privately-insured adults fared about the same as adults covered by Medicaid on eight (50 percent) of 16 quality measures examined. Clearly more research is needed in this area, and CMS and states will continue to work together to measure performance and use the data collected to drive improvements in the quality of health care.

There are several CMS initiatives currently underway to better understand what we know about, and how to improve, access and quality of care for adults enrolled in Medicaid. Many of these initiatives are focused in areas that align with the Adult Core Set domains. In 2012, for example, CMS awarded Adult Medicaid Quality Grants to 26 states to develop their staff capacity to report on the Adult Core Set measures and use that data in quality improvement projects linked to the Core Set measures.[62] These efforts focused on a range of topic areas, including behavioral health, substance use disorders, maternity care, and diabetes. Many of these projects are underway now. Additionally, CMS's Medicaid Innovation Accelerator Program (IAP) is providing states with targeted program support, tools, and technical resources related to: (1) substance use disorders; (2) Medicaid beneficiaries with complex needs and high costs; (3) community integration using long-term services and supports; (4) and physical/mental health integration.[63] In July 2014, CMS also launched a Maternal and Infant Health Initiative to drive improvements in the care

[59] Paradise, J. "Medicaid Moving Forward." Kaiser Family Foundation, March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

[60] Paradise, J. "Medicaid Moving Forward." Kaiser Family Foundation, March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

[61] Coughlin, T. et al. "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults." Kaiser Family Foundation, May 2013. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf; Kaiser Commission on Medicaid and the Uninsured. Health Coverage for Low-Income Americans, An Evidence-Based Approach to Public Policy, Figure 3 Jan 2007. Kaiser Family Foundation.

[62] More information about the Adult Medicaid Quality grants is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grants.html.

[63] Information about the IAP is available at http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html.

provided during the postpartum period to improve the health outcomes of Medicaid and CHIP enrollees.[64] The Initiative is part of a comprehensive effort to develop and implement evidence-based policies and programs in Medicaid and CHIP. Core Set findings showing relatively modest use of preventive services when compared to other measures in this report show the need for materials such as the recently-released CMS *Living Well* toolkit to support Medicaid agencies in improving use of preventive services.[65]

The quality measurement and improvement initiatives underway in the states and at CMS are gaining momentum to accelerate improvements in the quality of health care provided to adults enrolled in Medicaid. As the momentum to pay for value rather than volume of services grows, state-specific performance data will be critical in guiding efforts to transform the systems of care that provide services to Medicaid enrollees.

[64] Information about the Maternal and Infant Health Initiative is available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-18-2014.pdf. The goals of the initiative are to: (1) increase by 10 percentage points the rate of postpartum visits among pregnant women in Medicaid and CHIP in at least 20 states over a 3-year period, and (2) increase by 15 percentage points the use of effective methods of contraception in Medicaid and CHIP in at least 20 states over a 3-year period.

[65] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-tools/living-well/living-well.html.

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TABLES

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Table 1. Overview of State Reporting of the Medicaid Adult Core Set Measures, FFY 2014

	Number of Measures Reported	Flu vaccinations for Adults Ages 18 to 64	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women	Adult Body Mass Index Assessment	Screening for Clinical Depression and Follow-up Plan	Postpartum Care Rate	PC-01: Elective Delivery	PC-03: Antenatal Steroids	Antidepressant Medication Management	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Adherence to Antipsychotics for Individuals with Schizophrenia	Follow-Up After Hospitalization for Mental Illness	Medical Assistance With Smoking and Tobacco Use	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: LDL-C Screening	PQI 01: Diabetes Short-Term Complications Admission Rate	PQI 05: COPD and Asthma in Older Adults Admission Rate	PQI 08: Heart Failure Admission Rate	PQI 15: Asthma in Younger Adults Admission Rate	Plan All-Cause Readmissions	Annual Monitoring for Patients on Persistent Medication	Controlling High Blood Pressure	HIV Viral Load Suppression	Care Transition – Transition Record Transmitted to Health Care Professional	CAHPS Health Plan Survey 5.0H – Adult Questionnaire
U.S. Total	16.5 (Median)	15	31	33	32	26	5	34	12	3	31	24	21	30	16	34	34	25	24	25	25	21	27	19	3	4	18
Alabama	18	X	X	X	X	X	X	X	X	--	X	--	X	X	--	X	X	X	X	X	X	X	--	--	--	--	--
Arkansas	17	--	X	X	X	--	--	X	X	--	X	--	X	X	--	X	X	X	X	X	X	X	X	--	--	X	--
California	15	--	X	X	X	--	--	X	--	--	X	X	X	--	--	X	X	X	X	X	X	X	X	--	--	--	--
Colorado	21	X	X	X	X	X	--	X	X	--	X	X	X	--	X	X	X	X	X	X	X	X	X	X	--	--	X
Connecticut	17	--	X	X	X	X	--	X	--	--	X	X	X	X	--	X	X	X	X	--	X	X	X	X	--	--	--
Delaware	21	X	X	X	X	X	--	X	X	X	X	X	X	X	X	X	X	--	--	X	X	--	X	X	X	--	X
Dist. of Col.	14	X	--	X	X	X	--	X	--	--	X	X	--	X	X	X	X	--	--	--	--	--	X	X	--	--	X
Georgia	25	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X
Hawaii	14	--	X	X	X	X	--	X	--	--	X	X	--	X	--	X	X	--	--	--	--	X	X	X	--	--	X
Illinois	13	--	X	X	X	X	--	X	--	--	X	--	--	X	--	X	X	X	X	X	X	--	--	--	--	--	--
Indiana	18	--	X	X	X	X	X	X	--	--	X	X	X	X	--	X	X	X	X	X	X	X	X	--	--	--	--
Iowa	19	X	X	X	X	--	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X
Kentucky	15	X	X	X	X	X	--	X	--	--	X	X	--	X	X	X	X	--	--	--	--	--	X	X	--	--	X
Louisiana	21	X	X	X	X	--	--	X	X	--	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	--	X
Massachusetts	15	--	X	X	X	X	--	X	X	--	X	X	--	X	--	X	X	--	--	--	--	X	X	X	--	X	--
Michigan	14	--	X	X	X	X	--	X	X	--	X	--	--	--	--	X	X	X	X	X	X	--	X	--	--	--	--
Minnesota	18	X	X	X	X	X	--	X	--	--	X	X	--	X	X	X	X	X	X	X	X	--	--	X	--	--	X
Mississippi	13	--	X	X	X	X	--	X	--	--	X	X	--	X	--	X	X	--	--	--	--	--	X	X	--	--	X
Missouri	12	--	X	X	X	X	--	X	--	--	X	--	X	X	--	X	X	--	--	--	--	X	X	--	--	--	--
Montana	16	--	X	X	X	--	--	X	--	--	X	X	X	X	--	X	X	X	X	X	X	X	X	--	--	--	--
New Hampshire	16	X	X	X	--	--	--	X	X	--	X	--	--	X	X	X	X	X	X	X	X	--	X	--	--	--	X
New Mexico	15	--	X	X	X	X	--	X	--	--	X	--	X	--	--	X	X	X	X	X	X	X	X	--	--	--	--
New York	24	X	X	X	X	X	--	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X
Ohio	12	--	--	X	X	--	--	X	--	--	X	X	X	X	--	X	X	X	--	X	--	X	--	--	--	--	--
Oklahoma	15	X	X	X	X	X	--	X	--	--	--	--	--	X	X	X	X	X	X	X	X	--	--	--	--	--	X
Oregon	19	X	--	X	X	X	X	X	X	--	--	X	--	X	X	X	X	X	X	X	X	X	--	X	--	--	X
Pennsylvania	21	X	X	X	X	X	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X
Rhode Island	18	--	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	--	--	--	--	X	X	X	--	X	--
Tennessee	19	--	X	X	X	X	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	--	X	X	--	--	X
Texas	16	--	X	X	X	X	--	X	--	--	X	X	--	X	--	X	X	X	X	X	X	--	X	X	--	--	--

Table 1 (continued)

	Number of Measures Reported	Flu vaccinations for Adults Ages 18 to 64	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women	Adult Body Mass Index Assessment	Screening for Clinical Depression and Follow-up Plan	Postpartum Care Rate	PC-01: Elective Delivery	PC-03: Antenatal Steroids	Antidepressant Medication Management	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Adherence to Antipsychotics for Individuals with Schizophrenia	Follow-Up After Hospitalization for Mental Illness	Medical Assistance With Smoking and Tobacco Use	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: LDL-C Screening	PQI 01: Diabetes Short-Term Complications Admission Rate	PQI 05: COPD and Asthma in Older Adults Admission Rate	PQI 08: Heart Failure Admission Rate	PQI 15: Asthma in Younger Adults Admission Rate	Plan All-Cause Readmissions	Annual Monitoring for Patients on Persistent Medication	Controlling High Blood Pressure	HIV Viral Load Suppression	Care Transition – Transition Record Transmitted to Health Care Professional	CAHPS Health Plan Survey 5.0H – Adult Questionnaire
Vermont	21	X	X	X	X	X	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X
Virginia	8	--	X	--	--	--	--	X	--	--	X	--	--	X	--	X	X	--	--	--	--	--	--	--	X	--	--	X
Washington	17	--	X	X	X	X	--	X	--	--	X	X	X	X	--	X	X	X	X	X	X	X	X	X	--	--	--	--
West Virginia	15	--	X	X	X	X	--	X	--	--	--	--	X	X	--	X	X	X	X	X	X	X	--	X	X	--	--	--

Source: Mathematica analysis of FFY 2014 CARTS reports, as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.

X = measure was reported by the state; -- = measure was not reported by the state.

CARTS = CHIP Annual Reporting Template System; CAHPS = Consumer Assessment of Healthcare Providers and Systems; COPD = Chronic Obstructive Pulmonary Disease; HIV = Human Immunodeficiency Virus.

Table 2. Performance Rates on Frequently Reported Medicaid Adult Core Set Measures, FFY 2014

Measure	Measure Description	Number of States Reporting Using Core Set Specifications	Mean	Median	25th Percentile	75th Percentile
Primary Care Access and Preventive Care						
Breast Cancer Screening	Percentage of Woman Receiving Mammogram	31	51.5	52.5	46.2	59.2
Cervical Cancer Screening	Percentage Screened for Cervical Cancer	33	57.5	57.7	50.9	66.2
Chlamydia Screening	Percentage of Sexually Active Women Screened for Chlamydia	32	59.7	59.3	53.5	65.0
Body Mass Index (BMI) Assessment	Percentage with a BMI Value Documented	26	52.6	69.3	7.7	81.2
Maternal and Perinatal Health						
Postpartum Care Rate	Percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery.	34	54.4	58.2	42.5	63.9
Care of Acute and Chronic Conditions						
Comprehensive Diabetes Care	Percentage with diabetes (type 1 or type 2) who had a hemoglobin A1c (HbA1c) test	34	78.2	79.5	74.6	82.4
Comprehensive Diabetes Care	Percentage with diabetes (type 1 or type 2) who had a LDL-C screening test	34	68.4	67.6	64.2	75.6
Annual Monitoring for Patients on Persistent Medications	Percentage who received at least 180 treatment days of ambulatory medication therapy and annual monitoring	27	84.0	84.9	82.0	87.1
Behavioral Health						
Antidepressant Medication Management	Percentage Treated with Antidepressant Medication for 12 weeks	31	47.6	47.2	41.0	53.6
Antidepressant Medication Management	Percentage Treated with Antidepressant Medication for 6 months	31	31.4	31.2	24.9	36.7
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit within 7 Days	30	39.0	37.0	25.5	54.7
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit within 30 Days	30	56.7	57.3	45.0	71.9

Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.

This table includes frequently reported Adult Core Set measures, defined as measures reported by at least 25 states using Adult Core Set specifications. This table includes data for states that used Adult Core Set specifications to report the measures and excludes states that used other specifications and states that did not report the measures for FFY 2014. Additionally, rates were excluded if a state reported a denominator less than 30. Means are calculated as the unweighted average of all state rates. PQI 01, 08 and 15 were all reported by at least 25 states, but will not be publicly reported this year due to data quality issues that CMS is actively working to address in collaboration with states. Measure-specific tables are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Adult-Core-Set-Measures-FFY-2014.zip.

BMI = body mass index; CARTS = CHIP Annual Reporting Template System; CMS = Centers for Medicare & Medicaid Services.

Table 3. Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2014–2015 Reporting Cycle

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	Asthma/ COPD	Behav. Health[c,d]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes Care	ED Visits	Hospital Readmissions	Weight/ BMI	Other[e]
Total PIPs				565	22	154	35	17	22	101	34	91	10	115
Total States				34	11	20	11	7	7	20	12	15	7	17
Arizona	Varies by PIP	All	U	14	--	1*	--	--	--	--	--	13*	--	--
California	2013	All	A	41	--	1	2	2	--	9	--	23*	--	4
			A/C	1	1	--	--	--	--	--	--	--	--	--
			U	2	--	--	--	--	--	--	1	--	--	1
Colorado	FY2013–2014	All	A	3	--	1	--	--	--	--	--	--	1	1
			U	3	--	3	--	--	--	--	--	1	--	--
Florida	Varies by PIP	Some	A	27	--	1	1	--	1	8	--	1	--	15
			A/C	17	2	13*	--	--	--	--	--	2	--	--
			U	43	--	6	--	--	1	1	2	2	1	31
Georgia	2013	All	A	3	--	--	--	--	--	3*	--	--	--	--
			U	6	--	--	--	--	--	--	--	--	--	6*
Hawaii	Varies by PIP	All[f]	A	14	--	2	--	--	--	7*	--	5*	--	--
			A/C	2	--	--	--	--	--	--	--	--	2	--
Illinois	2012–2013	All[f]	U	4	--	--	--	--	2	--	--	2*	--	--
Iowa	2013	All	A	1	--	--	--	--	--	1	--	--	--	--
			A/C	1	1	--	--	--	--	--	--	--	--	--
Kansas	Varies by PIP	All[f]	A	3	--	--	--	--	--	3*	--	--	--	--
			A/C	2	--	2	--	--	--	--	--	--	--	--
Kentucky	2013	All	A	4	1	2	--	--	--	--	1	--	--	--
			A/C	6	1	2	--	--	--	--	3	--	--	--
			U	1	--	--	--	--	--	--	--	1	--	--
Louisiana	2013–2014	All[f]	A	4	--	--	4	--	--	--	--	--	--	--
			A/C	4	--	--	--	--	--	--	4*	--	--	--
Maryland	2013	All	A	6	--	--	--	6*	--	--	--	--	--	--
Massachusetts	Varies by PIP	All[f]	A	14	--	2*	--	1	--	3	--	7*	--	3
			U	5	--	5*	--	--	--	--	--	5*	--	--
Michigan	2013–2014	All	A	5	--	--	--	--	--	3	--	--	1	1
Minnesota	Varies by PIP	All	A	29	3	1	9*	--	5	9*	1	--	--	1
			A/C	3	--	--	--	--	--	--	--	--	--	--
			U	19	2	9*	--	--	2	--	1	1	--	6

Table 3 (continued)

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	Asthma/ COPD	Behav. Health[c,d]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes Care	ED Visits	Hospital Readmissions	Weight/ BMI	Other[e]
Mississippi	2013	All	A	5	--	--	--	3	--	2	--	--	--	--
			A/C	4	2	--	--	--	--	--	--	--	2	--
Missouri	2013	All[f]	A/C	1	--	1	--	--	--	--	--	--	--	--
			U	1	1	--	--	--	--	--	--	1	--	--
Nebraska	Varies by PIP	All	A	2	--	--	1	--	--	--	--	1	--	--
			A/C	4	--	1	--	--	--	--	3	--	--	--
			U	1	--	1	--	--	--	--	--	--	--	--
Nevada	2013–2014	All	A	1	--	--	--	--	--	1*	--	--	--	--
			A/C	2	--	--	--	--	--	--	2*	--	--	--
New Hampshire	2013–2014	All	A	5	--	2	--	--	--	3	--	--	--	--
			A/C	3	--	2*	--	--	--	--	--	--	--	1
			U	3	--	--	--	--	--	--	--	1	--	2*
New Jersey	2013	All	A	4	--	--	--	1	--	1	--	--	--	2
			U	1	--	--	--	--	--	--	--	--	1	--
New Mexico	2012–2013	All[f]	A	11	--	--	4	--	2*	5	--	--	--	--
			A/C	1	1	--	--	--	--	--	--	--	--	--
North Carolina	Varies by PIP	Some	A/C	1	--	--	--	--	--	--	--	--	--	1
			U	12	--	6	--	--	--	--	1	--	--	5
Ohio	2013	All[f]	A	7	--	--	--	--	--	7*	--	--	--	--
Oregon	Varies by PIP	Some	A	36	1	16*	1	1	--	16*	--	--	--	1
			U	13	--	6	--	--	--	--	1	4	--	5
Pennsylvania	Varies by PIP	Some	A	2	--	--	--	--	--	--	1*	--	--	1*
			A/C	5	--	5*	--	--	--	--	--	--	--	--
			U	20	--	11*	--	--	--	--	8*	12*	--	--
Rhode Island	2013	All	A	2	--	1	1	--	--	--	--	--	--	--
			A/C	4	--	--	--	--	--	--	--	--	--	4*
South Carolina	2013	All[f]	U	2	--	--	--	--	--	--	--	--	--	2
Tennessee	2013–2014	All	A	10	--	5	--	--	2	3	--	--	--	--
			A/C	3	--	3	--	--	--	--	--	--	--	--
			U	14	--	--	--	--	--	--	--	--	--	14
Utah	2012	All	A	3	--	1	1	--	--	1	--	--	--	--
			A/C	1	--	1	--	--	--	--	--	--	--	--
			U	9	--	9	--	--	--	--	--	--	--	--
Virginia	2013	All	A/C	7	--	7*	--	--	--	--	--	--	--	--

Table 3 (continued)

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	Asthma/ COPD	Behav. Health[c,d]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes Care	ED Visits	Hospital Readmissions	Weight/ BMI	Other[e]
Washington	2014	All	A	8	--	2	2	--	--	--	1	2	1	1
			U	15	--	8	--	--	6*	--	--	5*	1	2
West Virginia	2013	All[f]	A	3	--	--	--	--	--	3	--	--	--	--
			A/C	3	3*	--	--	--	--	--	3*	--	--	--
Wisconsin	FY2013–2014	Some	A	24	--	--	8	3	--	12	--	1	--	3
			A/C	7	--	7	--	--	--	--	--	--	--	--
			U	15	2	8	1	--	1	--	1	1	--	1

Source: EQR technical reports submitted to CMS for the 2014–2015 reporting cycle, as of April 30, 2015.

Notes: During the 2014–2015 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. ID recently implemented an MCO for its dual eligible population; it has not yet produced an EQR report. In addition, IN, PR, and TX did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis. While VT is required to conduct an EQR under the terms of its section 1115 demonstration, its managed care entity is neither an MCO nor PIHP and therefore is excluded from this analysis.

Four states that submitted EQR technical reports are excluded from this table. EQR technical reports for DE and NY did not include any information about PIPs. The only PIPs reported in the EQR technical reports for DC and ND focused exclusively on children or pregnant women and are not included in this table.

This table includes PIPs targeting adults from the submitted EQR technical reports, including PIPs that also targeted children and pregnant women. PIPs that exclusively target children or pregnant women are included in Table 3 of the 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

PIPs that focused on multiple topic areas are shown in all of the relevant topics. Each PIP is included only once in the number of PIPs for each state, so the number of PIPs in the topic areas may not sum to the total count in some states.

[a] Use of the term "validation" differed across EQR reports. In this analysis, validation indicates that the EQRO reported reviewing information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis. Some PIPs that were reviewed in the validation process did not meet all of the review criteria.

[b] PIPs are categorized based on the target population as described in the EQR technical reports. A=Adults Only; A/C = Adults and Children; U = Unspecified ages. PIPs that target children or pregnant women exclusively are not included in this table.

[c] The Behavioral Health category includes PIPs that focus on tobacco cessation and treatment of mental health and substance use disorders (SUDs) including use of alcohol and other drugs.

[d] During the 2014–2015 reporting cycle, the following states had PIPs that focused on substance use disorder: Arizona (1 PIP and 1 collaborative PIP across 13 MCOs); California (1 PIP); Hawaii (1 PIP); Kansas (1 PIP); Massachusetts (7 PIPs); Oregon (3 PIPs); Tennessee (1 PIP); Utah (1 PIP); Wisconsin (11 PIPs).

[e] Other PIP topic areas include member satisfaction (FL, GA, NH, SC), advance care directives (CA, FL, OR), balance billing (FL, TN), access to care (MI, SC), fall rate (PA, WI), care for older adults (CA), use of high-risk medication in the elderly (CA), annual monitoring for patients on persistent medication (CA), patient experience (CA), medication review (FL), call center timeliness (FL), use of a patient-centered care plan (FL), satisfaction with health plan (FL), improving access to culturally and linguistically appropriate services (FL), reducing disparities in cultural competence among practicing physicians (FL), first call resolution (FL), telephone answer speed (FL), using an organization assessment to implement trauma-informed care (FL), improved satisfaction with cultural and language services with people living with HIV/AIDS (FL), timeliness of services for long-term care services (FL), electronic health records with meaningful use (FL), number of health risk assessments (FL), number of community health workers (FL), home-based medication reconciliation after hospital discharge (MN), increasing annual preventive and diagnostic dental services (MN), medication management (NJ), call rollover (NC), decreasing concurrent requests for reauthorization of care while in an inpatient setting (NC), improving the accuracy of level of care assessments on authorization requests (NC), improving compliance with first appointment time frames for urgent cases (NC), increasing provider networks use and implementation of evidence-based practices (NC), timely submission of update assessments (NC), stakeholder access to patient information (NC), community outreach program for members who are super-utilizers (OR), number of patient-centered primary care medical home users (OR), initial health screens for special enrollment populations (RI, WA), timely recredentialing of providers (TN), cultural assessment and cultural integration survey (TN), accountable and collaborative care (WA), and reducing member grievance calls (WA). CD4 count and viral load testing (CA, FL), access to preventive/ ambulatory care services (CO), chlamydia screening in women (MN, RI), improving adherence to statins (NJ), and integrating chronic pain management into primary care (OR).

Table 3 (continued)

[f] This state's EQRO validated all of the PIPs mentioned in the technical report; it was unclear whether any additional PIPs were conducted, but not validated or mentioned in the technical report.

* PIP topic was mandated by the state.

A = Adults only; A/C = Adults and children; Behav. = Behavioral; BMI = body mass index; CHIP = Children's Health Insurance Program; COPD = chronic obstructive pulmonary disease; EPSDT = Early and Periodic Screening, Diagnostic and Treatment; EQRO = External Quality Review Organization; FY = fiscal year; MCO = managed care organization; PIHP = prepaid inpatient health plan; U = Unspecified ages.

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FIGURES

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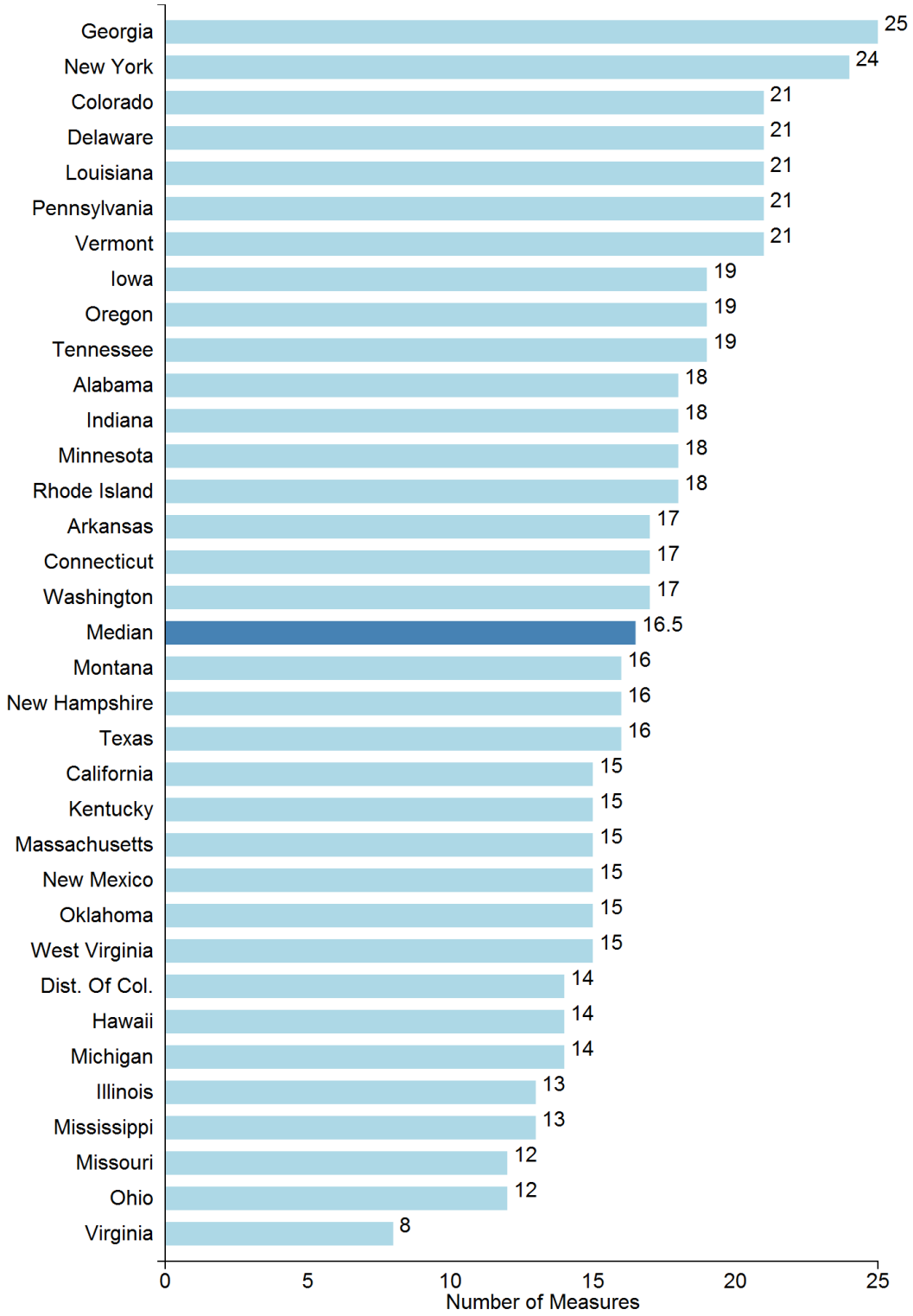
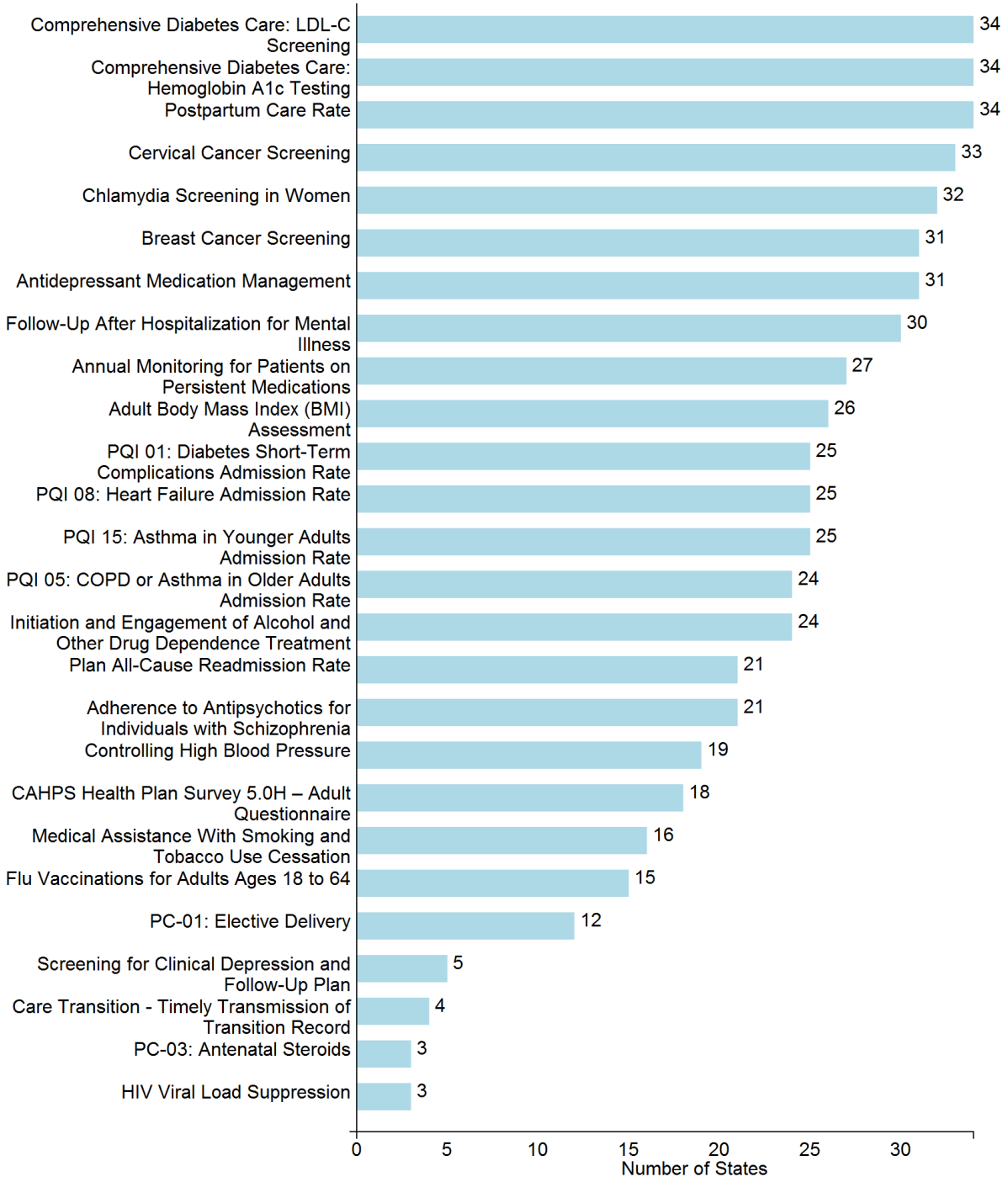
Figure 1. Number of Medicaid Adult Core Set Measures Reported by States, FFY 2014



Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.
This figure is based on state reporting of 26 Core Set measures for FFY 2014.

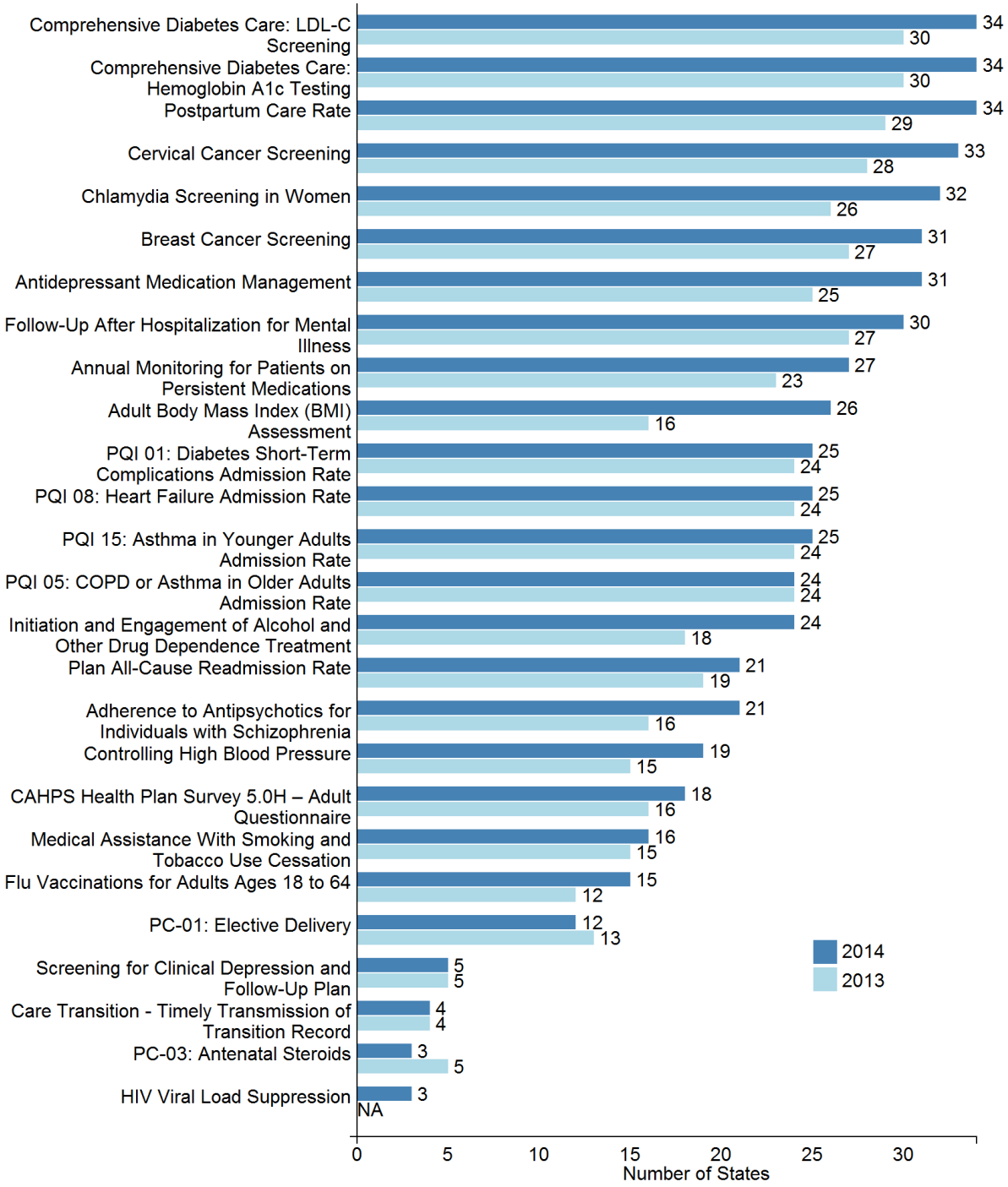
Figure 2. Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2014



Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.
This figure is based on state reporting of 26 Core Set measures for FFY 2014.

Figure 3. Changes in the Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013–2014



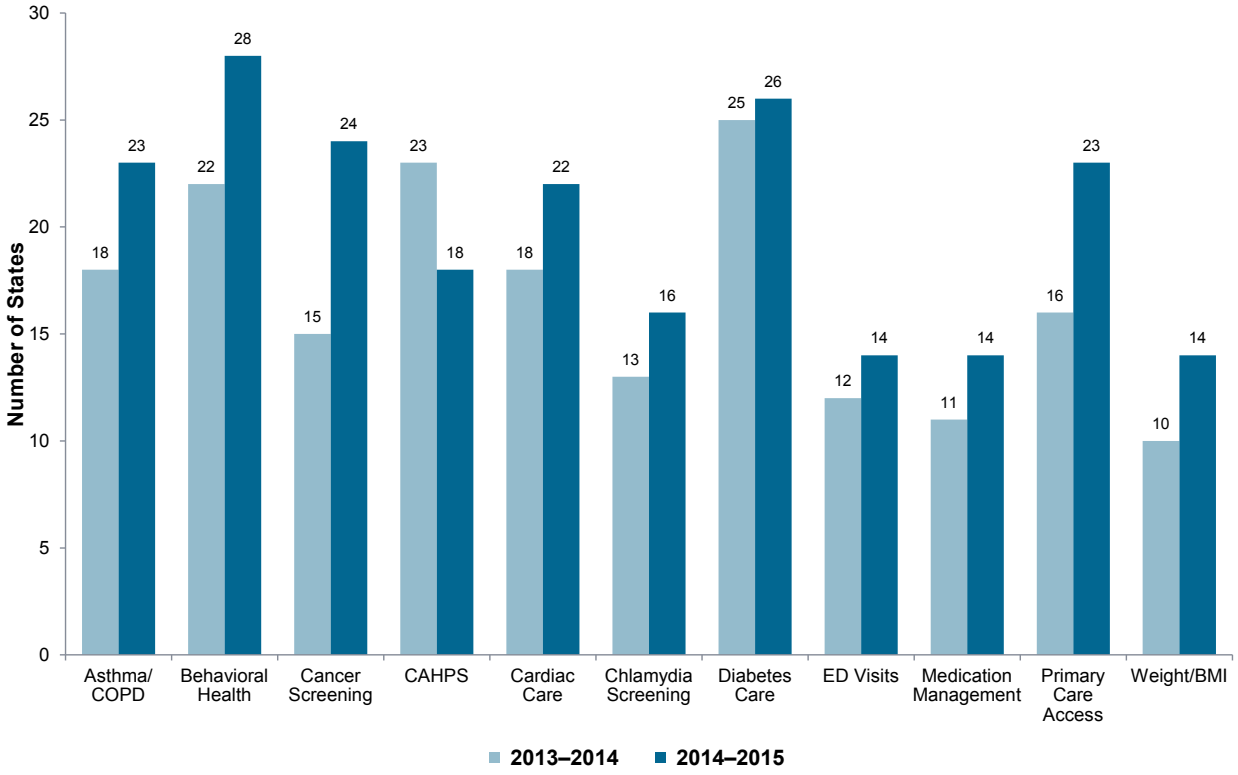
Source: Based on Mathematica analysis of FFY 2013–2014 Adult CARTS reports as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.

The FFY 2013 and FFY 2014 Medicaid Adult Core Sets both include 26 measures. The Annual HIV Medical Visit measure was included in the FFY 2013 Core Set, but was retired for FFY 2014 reporting. This measure was replaced by the HIV Viral Load Suppression measure for FFY 2014.

NA = measure was not collected for FFY 2013.

Figure 4. Comparison of Performance Measures Evaluating Adults' Health Care Quality that were Reported in External Quality Review (EQR) Technical Reports for the 2013–2014 and 2014–2015 Reporting Cycles for 33 States, by General Topic



Sources: Performance measures for 2013–2014 obtained from the 2014 Secretary's Report on the Quality of Care for Adults in Medicaid. Performance measures for 2014–2015 are based on Mathematica Policy Research analysis of 2014–2015 EQR technical reports.

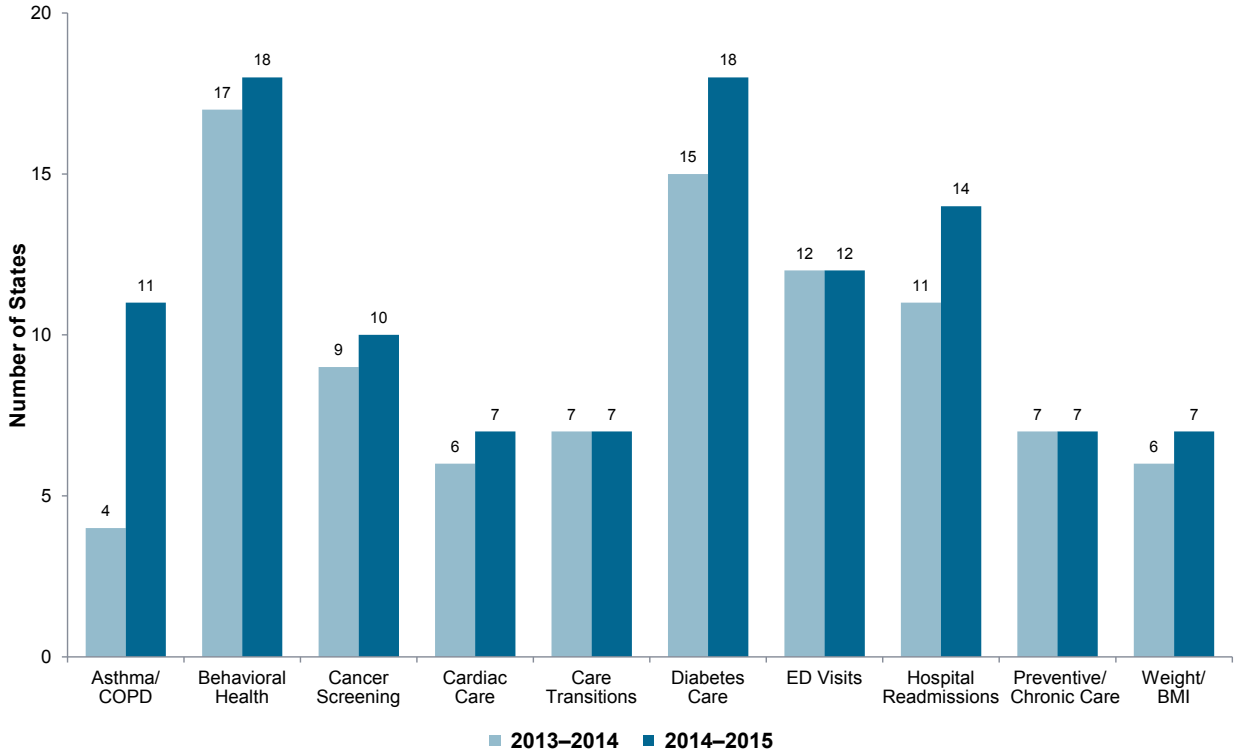
Notes: States include AZ, CA, CO, DC, FL, GA, HI, IL, IA, KS, KY, LA, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, NC, OH, OR, PA, RI, SC, TN, VA, WA, WV, and WI. These are the states that reported performance measures in both comparison years.

The Behavioral Health category includes performance measures that focus on tobacco cessation and treatment of mental health and substance use disorders (SUDs) including use of alcohol and other drugs.

Information about the EQR process is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHIP = Children's Health Insurance Program; COPD = chronic obstructive pulmonary disease; ED = emergency department; MCO = managed care organization; PIHP = prepaid inpatient health plan; PIP = performance improvement project; SUD = substance use disorder.

Figure 5. Comparison of Performance Improvement Projects (PIPs) Targeting Adults that were Reported in External Quality Review (EQR) Technical Reports for the 2013–2014 and 2014–2015 Reporting Cycle for 32 States, Selected Topics



Sources: PIPs for 2013–2014 were obtained from the 2014 Secretary's Report on the Quality of Care for Adults in Medicaid and CHIP. PIPs for 2014–2015 are from Mathematica Policy Research analysis of 2014–2015 EQR technical reports.

Notes: States include AZ, CA, CO, FL, GA, HI, IL, IA, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NV, NJ, NM, NC, OH, OR, PA, RI, SC, TN, VA, WA, WV, and WI. These are the states that reported PIPs in both comparison years.

The Behavioral Health category includes PIPs that focus on tobacco cessation and treatment of mental health and substance use disorders (SUDs) including use of alcohol and other drugs.

Information about the EQR process is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

BMI = body mass index; CHIP = Children's Health Insurance Program; COPD = chronic obstructive pulmonary disease; ED = emergency department; MCO = managed care organization; PIHP = prepaid inpatient health plan; PIP = performance improvement project; SUD = substance use disorder.

GLOSSARY

ABA	Adult Body Mass Index Assessment
Affordable Care Act	The Patient Protection and Affordable Care Act
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AMM	Antidepressant Medication Management
AOD	Alcohol or Other Drug
BCS	Breast Cancer Screening
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CD4	Cluster of Differentiation 4
CDF	Screening for Clinical Depressions and Follow-Up Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHL	Chlamydia Screening in Women
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPA	CAHPS Health Plan Survey 5.0H – Adult Questionnaire
CTR	Care Transition – Timely Transmission of Transition Record
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFY	Federal Fiscal Year
FUH	Follow-Up After Hospitalization for Mental Illness
FVA	Flu Vaccinations for Adults Ages 18 to 64
FY	Fiscal Year
HA1C	Comprehensive Diabetes Care: Hemoglobin A1c Testing
HbA1c	Hemoglobin A1c
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIO	Health Insuring Organization
HIV	Human Immunodeficiency Virus
HVL	HIV Viral Load Suppression
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
LDL	Comprehensive Diabetes Care: LDL-C Screening

LEP	Limited English Proficiency
LTSS	Long-Term Services and Supports
MAP	Measure Applications Partnership
MAX	Medicaid Analytic eXtract
MCO	Managed Care Organization
MPM	Annual Monitoring for Patients on Persistent Medication
MSC	Medical Assistance with Smoking Cessation
NA	Not Available
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PC-01	Elective Delivery
PC-03	Antenatal Steroids
PCP	Primary Care Practitioner/Provider
PCR	Plan All-Cause Readmission Rate
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Postpartum Care Rate
PQI 01	Diabetes Short-Term Complications Admission Rate
PQI 05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI 08	Hearth Failure Admission Rate
PQI 15	Asthma in Younger Adults Admission Rate
SAA	Adherence to Antipsychotics for Individuals with Schizophrenia
SUD	Substance Use Disorder
TA/AS	Technical Assistance and Analytic Support
TEFT	Testing Experience and Functional Assessment Tools