Report to Congress

Efforts to Improve the Quality of Health Care for Children and Adults Enrolled in Medicaid and the Children's Health Insurance Program (CHIP) 2017-2019

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I. INTRODUCTION

Medicaid and the Children's Health Insurance Program (CHIP) are critical components of the health care system, providing coverage to approximately 70.6 million people in December 2019. This includes 63.9 million individuals enrolled in Medicaid and 6.6 million individuals enrolled in CHIP. Of the 70.6 million enrolled in December 2019, just over 35 million were enrolled in CHIP or were children enrolled in the Medicaid program, representing half of total enrollment.[1]

Between 2017 and 2019, the Centers for Medicare & Medicaid Services (CMS) worked to improve state flexibility, and, in an effort to increase value across the health care delivery system, focused on transparency to create stronger accountability. In addition, CMS focused on program integrity. Highlights of these priority areas include efforts to allow states to implement demonstrations to meet the needs of their beneficiaries, such as 1115 demonstrations that give states flexibility to address Substance Use Disorders (SUDs) identified within their Medicaid populations, and to phase in state-specific solutions over time; movement to more data driven strategies and improvement in reporting and quality of Transformed Medicaid Statistical Information System (T-MSIS) data; and the release of a new program integrity strategy to enhance the accountability of federal and state oversight of the Medicaid program. This report highlights many additional activities that address these priority areas and also reflects efforts to ensure that Medicaid and CHIP programs meet the needs of their Medicaid and CHIP beneficiaries and provide high quality health care.

To better monitor the quality of care Medicaid and CHIP beneficiaries receive and their access to care, CMS established the Medicaid and CHIP Child and Adult Core Sets. The Child Core Set was established under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L.111-3) and states began reporting the measures in Federal Fiscal Year (FFY) 2011. The Adult Core Set was established under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act; P.L. 111-148) and states began voluntarily reporting the measures in FFY 2013. CMS annually releases information on state progress in reporting the Child[2] and Adult[3] Core Sets measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality. The Medicaid and CHIP Child Core Sets serve as the foundation for the State Health System Performance pillar of the MAC Scorecard.

Updated annually, the Child and Adult Core Sets include measures targeting specific clinical domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, and (5) Dental and Oral Health Care (Child Core Set only). In addition, both Core Sets include Experience of Care measures using the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

[1] https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/september-medicaid-chip-enrollment-trend-snapshot.pdf

[2] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html

[3] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html

Sections 1139A(a)(6) and 1139B(b)(4) of the Social Security Act, as amended by section 401 of CHIPRA and section 2701 of the Affordable Care Act, respectively, direct the Secretary of Health and Human Services (HHS) to produce a report to Congress every three years, addressing the following:

- The Secretary's efforts to improve:
  - Quality related to the duration and stability of health insurance coverage under Medicaid (Title XIX) and the Children's Health Insurance Program (CHIP, Title XXI);
  - The quality of health care for children and adults under such titles, including preventive health services, dental care, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions, and to aid in the growth and development of infants, young children, school age children, and adolescents with special health care needs;
  - The quality of health care for children and adults under such titles across the dimensions of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;
- The status of voluntary reporting of quality measures by states under Medicaid and CHIP, using the Child and Adult Core Sets (see Appendix); and
- Recommendations for legislative changes needed to improve the quality of care provided to children and adults under these titles, including quality reporting by states.

This report describes the efforts undertaken by HHS between 2017 and 2019 to advance access and quality of care for children and adults enrolled in Medicaid and CHIP (Chapter II), the status of state reporting of the Child and Adult Core Set measures (Chapter III), and recommendations for legislative changes needed to improve the quality of care in Medicaid and CHIP (Chapter IV).

II. HHS EFFORTS TO IMPROVE ACCESS AND QUALITY OF CARE FOR CHILDREN AND ADULTS

This section focuses on efforts and opportunities for states to enroll those who are eligible for Medicaid and CHIP as well as efforts to improve both utilization and outcomes of Medicaid and CHIP services. Specifically, section II. A. identifies efforts to increase access to and stability of coverage, section II. B. identifies efforts to increase access to and quality of care, and section II. C. identifies program and policy levers that support all of these efforts.

A. Efforts to Enhance Access to Coverage and Improve the Duration and Stability of Health Insurance Coverage

Continuous health care coverage has been shown to have a positive impact on a range of health behaviors and outcomes, including improved access to care, improved health status, decreased cost burden, and extended life span.[4] Medicaid and CHIP coverage improves self-reported health status and quality of life, and is associated with decreased mortality rates for infants, children, and adults.[5] Adults with coverage are more likely to receive preventive care and screenings on a timely basis, reducing the risk of late-stage diagnoses and improving prognoses.[6]

Medicaid and CHIP coverage are also key to addressing public health crises, including alcohol and opioid use disorders. In 2017, nearly 40 percent of nonelderly adults with opioid use disorder (OUD) were covered by Medicaid.[7] Pregnant women with Medicaid were more likely to receive adequate prenatal care than uninsured women.[8] Moreover, access to Medicaid coverage reduces racial and ethnic disparities in the receipt of preventive care services.[9] Importantly, there is strong evidence that health benefits from enrollment in Medicaid and CHIP have generational persistence, with coverage in early childhood predicting infant health in the next generation.[10]

To improve population health outcomes, CMS partners with states to expand and improve access to high-quality health care coverage under Medicaid and CHIP. Health insurance coverage for vulnerable populations also furthers other high priority initiatives such as preventing and treating opioid use disorder, improving maternal and infant health outcomes, and preventing and managing chronic disease. This section highlights HHS's efforts to advance efforts to improve Medicaid and CHIP coverage between 2017 and 2019.

[4] https://www.rwjf.org/en/library/research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html

[5] https://www.rwjf.org/en/library/research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html

[6] https://www.ncbi.nlm.nih.gov/books/NBK220636/

[7] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/

[8] https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf

[9] https://www.ncbi.nlm.nih.gov/books/NBK220636/

[10] https://www.nber.org/papers/w23810

1. Efforts to Ensure Access to Medicaid and CHIP Coverage

CMS strives to ensure health care access for the nation's most vulnerable populations through Medicaid and CHIP, while at the same time providing states with flexibility to develop strategies for covering diverse populations. CHIP is an integral part of states' ability to ensure that vulnerable children have access to health care services.

- **CHIP Reauthorization.** The Medicare and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) extended CHIP for only two years, with the expiration of funding on September 30, 2017. Although Congress typically acts prior to the program's expiration date, CHIP funding lapsed between October 1, 2017, and January 22, 2018, as Congress debated approving this funding and the federal budget overall. States had carryover funds to varying extents, and while CHIP continued to operate, several states were stretched to within their last few months of funding and needed to notify beneficiaries. During this time of uncertainty, CMS conducted five all-state webinars devoted to contingency planning and provided dozens of one-on-one technical assistance calls to states. In early 2018, Congress voted to extend federal funding for states' administration of the CHIP program through September 30, 2027, ensuring coverage remains available for the more than 6 million children who receive care through the program. This extension was enacted through the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (referred to as the HEALTHY KIDS Act, P.L. 115-120, section 3001 et seq.) and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act, P.L. 115-123, section 50100 et seq.).[11] In addition to extending CHIP allotment appropriations through FFY 2027 under section 2104(e) of the Social Security Act (the Act), the Child Enrollment Contingency Fund, under section 2104(n) of the Act, makes federal funds available for a fiscal year if a state anticipates expenditures above the available CHIP allotments and their current CHIP enrollment exceeds a statutorily-determined target. Moreover, the Act's maintenance of effort provisions ensure that states do not restrict eligibility for CHIP beyond certain thresholds, assuring that in-need children continue to have access to health care.
- **Connecting Kids to Coverage.** Since 2009, the Connecting Kids to Coverage program has supported the enrollment and retention of eligible children in Medicaid and CHIP through grant awards to states, providers, tribal entities, schools, community organizations, and other eligible entities, and through a national public awareness campaign (referred to as the National Campaign).

  Section 303 of MACRA, (P.L. 114-10) extended the CHIP component of Connecting Kids to Coverage Outreach and Enrollment Program through FFY 2017. It provided an additional $40 million in funding; of which, pursuant to section 2113 of the Act, $32 million was dedicated to general outreach and enrollment grants, $4 million was dedicated to grants targeting the enrollment of American Indian/Alaska Native children (AI/AN), and $4 million was dedicated to the National Campaign. Between 2017 and 2019, CMS provided technical assistance and monitored the performance of 38 grantees funded under the broader outreach and enrollment funding opportunity and eight grantees that focused on the outreach and enrollment of AI/AN children. In total, these 46 grantees helped with over 178,000 child

[11] https://www.medicaid.gov/federal-policy-guidance/downloads/sho18010.pdf

applications or renewal forms, leading to 133,566 child enrollments and renewals in Medicaid and CHIP. Many of these grants also supported the enrollment of eligible parents since research show that including parents in the outreach and enrollment efforts is an effective pathway for enrolling more children. The 37 grantees that reported parent outcomes enrolled and renewed more than 39,000 parents in public coverage.

Section 3004 of the HEALTHY KIDS Act provided $120 million for activities aimed at reducing the number of children who are eligible for, but not enrolled in, Medicaid and CHIP, and improving retention of enrolled children. Of the total $120 million in funding, 10 percent, or $12 million, is set aside for outreach to AI/AN children and another 10 percent is set aside for the National Campaign. The remaining, $96 million, supports grant awards for outreach and enrollment of uninsured children and their parents.

On June 19, 2019, CMS announced $48 million in cooperative agreement awards for 39 organizations.[12] An additional $48 million in funding from the HEALTHY KIDS Act will be made available in a subsequent funding opportunity. Eligible entities awarded cooperative agreements include state and local governments, Indian tribes, tribal consortia, urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act, federal safety net organizations, community-based organizations, faith-based organizations, and schools.

In July 2019, CMS announced a $6 million funding opportunity that targets increasing the enrollment and retention of eligible AI/AN children in Medicaid and CHIP. Awards are expected to be made in January 2020. An additional $6 million in funding from the HEALTHY KIDS Act will be made available in a subsequent funding opportunity for additional grants targeting AI/AN children.

The Connecting Kids to Coverage National Campaign, has produced various resources to help outreach partners connect kids to coverage and share information about Medicaid and CHIP resources. Outreach materials have focused on back-to-school; delivery of preventive services, including immunizations; and oral health. Available tools consist of customizable materials such as social media messages; print materials such as posters, flyers, direct mail inserts, newsletter and article templates; and radio and television public service announcements (PSAs).[13] Key activities between 2017 and 2019 include:

- **Radio Media Tours**
    - Annual back-to-school radio media tour to promote Medicaid and CHIP enrollment. Two tours were held in August 2019. Radio interviews aired nationally, and were targeted to the Atlanta, GA; Chicago, IL; Dallas-Ft. Worth, TX; Miami, FL; Orlando, FL; Pittsburgh, PA; and Washington, DC markets. In addition to statewide in Kansas and Montana.
    - 2019 immunization awareness radio media tour to promote Medicaid and CHIP coverage of vaccines. Radio interviews aired nationally as well as in markets such as Abilene-Sweetwater, TX; Atlanta, GA; Corpus Christi, TX; Dallas-Ft. Worth, TX;

[12] https://www.insurekidsnow.gov/campaign-information/outreach-enrollment-grants/2019-healthy-kids-outreach-and-enrollment/index.html

[13] https://www.insurekidsnow.gov/library/index.html

Los Angeles, CA; Orlando, FL; Phoenix, AZ; Sacramento, CA; San Diego, CA; Savannah, GA; Tampa, FL; Tallahassee, FL; and Tucson, AZ.

  - In 2019, there were a total of 26 interviews in both English and Spanish which resulted in 1,068 airings and estimated impressions of 34.7 million.

- **TV and Radio PSAs**
  - Biannual (during back-to-school season and open enrollment) pitch to television and radio stations to air "Get Covered" PSA. PSAs have aired in all of the CMS regions and nationally on FOX Business News, FOX, REVOLT TV, and the Pac-12 Network. Between 2018-2019, it is estimated that these PSAs yielded more than 414 million impressions.
- **Webinars for Community-based Organizations, Providers, States, and other Partners**
  - Increasing Health Care Access for Teens through Medicaid and CHIP
  - Connecting Students to Coverage This Back-to-School Season
  - Outreach and Enrollment Strategies to Reach Rural Families
  - Connecting Kids to Coverage National Campaign Resources
  - Engaging Parent Mentors to Increase Participation of Eligible Children in Medicaid and CHIP
- **Materials Developed**
  - Renewal Palmcards
  - Tip Sheet on Rural Outreach
  - Spotlight Video on Mountain Comprehensive Health Corporation in Whitesburg, Kentucky
  - Quarterly eNewsletters issued to CKC subscribers
  - Matte articles circulated annually during back-to-school season to promote Medicaid and CHIP enrollment
  - 2019 Matte article circulated on Medicaid and CHIP coverage of vaccines
  - Monthly tweets distributed to promote Medicaid and CHIP enrollment through @IKNGov Twitter handle

- **Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.** The SUPPORT Act (P.L. 115-271), passed in October 2018, included a number of Medicaid and CHIP provisions to address the opioid crisis, some of which are listed below.[14]
  - Prohibits termination of Medicaid eligibility for juveniles under age 21 or former foster care youth up to age 26 who are inmates of public institutions. Also requires states to redetermine eligibility prior to release without requiring a new application and if still eligible, restore Medicaid coverage upon release. (Section 1001)

[14] https://www.congress.gov/bill/115th-congress/house-bill/6

- Requires states to ensure that Medicaid foster care youth who were enrolled at age 18 can retain coverage in any state up to age 26 from any state, eliminating the need for a section 1115 waiver to cover former foster care youth from other states. (Section 1002)
- Authorizes new demonstrations to increase Medicaid substance use-disorder (SUD) provider capacity. (Section 1003)
- Requires state Medicaid programs to establish drug utilization review safety edits for opioid refills and an automated claims review process to identify refills in excess of state limits; also requires Medicaid programs to monitor concurrent prescribing of opioids and benzodiazepines or antipsychotics. (Section 1004)[15]
- Requires HHS to issue guidance for states as to how care can be improved for infants with neonatal abstinence syndrome (NAS) and their families. (Section 1005)[16]
- Extends enhanced federal matching rate under section 1945 of the Act from 8 quarters to 10 quarters for certain SUD-focused Medicaid health homes.[17] Also requires states to cover all drugs and biologicals approved or licensed by the FDA for medication-assisted treatment (MAT) to treat opioid use disorder, as well as related counseling services and behavioral therapy, for a five-year period beginning October 1, 2020. (Section 1006)
- Creates a Medicaid state plan option to add residential pediatric recovery centers as a provider type for inpatient or outpatient services for infants under age 1 with NAS and their families. (Section 1007)[18]
- Requires publication of guidance to states regarding federal reimbursement for furnishing services and treatment for substance use disorders under Medicaid using services delivered via telehealth, including in School-Based Health Centers. (Section 1009)
- Requires publication of guidance or updated guidance to states on mandatory and optional items and services, for non-opioid treatment and management of pain. (Section 1010)[19]
- Authorizes Medicaid payments for services provided outside of institutions for mental disease (IMDs) for pregnant and postpartum women receiving IMD SUD services. (Section 1012)[20]
- Requires publication of the Transformed Medicaid Statistical Information System (T-MSIS) SUD data book. (Section 1015)[21]

[15] https://www.medicaid.gov/federal-policy-guidance/downloads/cib080519-1004.pdf

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf

[17] https://www.medicaid.gov/federal-policy-guidance/downloads/cib050719.pdf

[18] https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf

[19] https://www.medicaid.gov/federal-policy-guidance/downloads/cib022219.pdf

[20] https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf

[21] https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/sud-data-book.pdf

- Requires state Medicaid programs to report annually on behavioral health quality measures included in the Medicaid Adult Core Set beginning in 2024. (Section 5001)
- Requires all state CHIP programs to include coverage of mental health services, including behavioral health treatment, for both children and pregnant women. (Section 5022)
- Requires state Medicaid programs to have certain providers check prescription drug monitoring programs for certain enrolled beneficiaries' prescription drug history before prescribing a controlled substance. (Section 5042)
- Creates a state plan option to partially lift the IMD payment exclusion by allowing states to use federal Medicaid funds for IMD and other medically necessary services for nonelderly adults with a SUD for up to 30 days in a 12-month period, between 10/1/19 and 9/30/23. (Section 5052)[22]

2. Efforts to Improve Enrollment and Renewal Processes

The modernization of Medicaid and CHIP enrollment and renewal processes not only reduces state burden, but empowers patients to navigate the health care system independently. and access the coverage they need, when they need it. Improvements in eligibility, enrollment, and renewal processes have enabled many states to reduce the processing time for eligibility determinations. The applicant experience has also been updated to align with current technology standards. As a result, individuals are able to apply for Medicaid coverage online in all 50 states, and the majority of states can complete real-time determinations and automated renewals.[23]

- **Efforts to Ensure State Processes and Systems Support Timely and Accurate Eligibility Determination Processes**
  - **Improved State Processing Time for Medicaid Modified Adjusted Gross Income (MAGI) and CHIP Applications.** States have made tremendous strides in increasing the efficiency of their eligibility and enrollment processes and systems. This includes adoption of the single streamlined application for all insurance affordability programs; increased availability of and primary reliance on electronic verification; coordination between Medicaid, CHIP, and the Exchanges; the adoption of MAGI to simplify household composition and income counting rules across programs; and data-driven renewal processes. The combination of investment in the use of technology and eligibility systems and significant process improvements has led to states' ability to process determinations more accurately, timely, and efficiently, with many states able to determine eligibility in real time for some applicants. All MAGI eligibility determinations on applications generally must be completed within 45 days as required by federal regulations at 42 CFR 435.912(c) and 457.340(d). CMS expects states to make eligibility determinations for applicants in compliance with federal timeline standards and continuously monitors and informs states of their application processing times.

[22] https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf

[23] https://ccf.georgetown.edu/wp-content/uploads/2019/03/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2019.pdf

In November 2018, CMS published state processing time data from 42 states that showed that between February and April 2018, nearly 50 percent of all MAGI determinations on applications were conducted in less than 7 days and that over 30 percent of all MAGI determinations on applications were conducted in under 24 hours.[24] The November 2019 report, reflecting data between February and April 2019 for 46 states, showed an increase, with nearly 57 percent of all MAGI determinations on applications processed in less than 7 days. In addition, over 43 percent of all MAGI determinations on applications were conducted in under 24 hours.[25] This information was submitted by states as part of the Medicaid and CHIP Eligibility and Enrollment Performance Indicators process[26] and is included in the State Administrative Accountability Pillar of the MAC Scorecard.[27]

- **Medicaid Program Integrity.** In June 2018, CMS announced a new Medicaid Program Integrity Strategy to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. This strategy includes implementing the revised Medicaid Eligibility Quality Control (MEQC) program for continuous oversight of states' eligibility determinations; auditing Medicaid managed care plans' financial reporting and Medical Loss Ratios to ensure that plans are not overpaid; enhancing data sharing collaboration efforts in both Medicare and Medicaid; sharing promising program integrity practices with states; training and educating state Medicaid program integrity staff through the Medicaid Integrity Institute; and conducting state program integrity reviews to assess the effectiveness of state program integrity efforts.[28]
- **Oversight of State Medicaid Claiming and Program Integrity Expectations.** In June 2019, CMS reminded states of the mutual obligations and accountability of state and federal governments for the integrity of the Medicaid program and the safeguards necessary to ensure proper and appropriate use of both federal and state dollars.[29] CMS has identified necessary assurances that should be made when a state submits a state plan amendments (SPA) or demonstration proposal, and has provided states with program readiness checklists to support states' compliance with existing federal requirements addressed in these assurances. The June 2019 Informational Bulletin provided a Program Readiness Checklist to assist states in ensuring operational capacity to make accurate eligibility determinations and claim FFP at the appropriate matching rate. It also noted that states are required to have systems in place that perform payment operations and support claiming at the appropriate FMAP or administrative federal matching rates. This

[24] https://www.medicaid.gov/state-overviews/downloads/magi-and-chip-application-processing-time/magi-application-time-report.pdf

[25] https://www.medicaid.gov/state-overviews/downloads/magi-and-chip-application-processing-time/magi-application-time-report-2019.pdf

[26] https://www.medicaid.gov/state-overviews/downloads/magi-and-chip-application-processing-time/magi-application-time-report.pdf

[27] https://www.medicaid.gov/state-overviews/scorecard/medicaid-magi-and-chip-application-processing-times/index.html

[28] https://www.cms.gov/About-CMS/Components/CPI/Medicaid-PI-Strategy.html

[29] https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf

includes a comprehensive test plan and an end-to-end testing strategy. CMS has been working with states as SPAs and section 1115 demonstrations for the new adult group are approved to ensure that states have plans in place to meet the program integrity expectations, especially with respect to systems programming and staff training.

- **Payment Error Rate Measurement (PERM).** The PERM program measures improper payments in Medicaid and CHIP and produces improper payment rates for each program. The improper payment rates are based on review of the fee-for-service (FFS), managed care, and eligibility components of a state's Medicaid and CHIP program for the fiscal year that is under review. States are audited on a three-year cycle.[30] For each PERM cycle, states must establish state-specific corrective action plans (CAPs) to address the root causes of identified Medicaid and CHIP errors and deficiencies. After a three-year hiatus from 2015 to 2018, during which the eligibility component of PERM was suspended and states implemented Eligibility Review Pilots, in FFY 2019 CMS resumed reporting an improper payment rate for the eligibility component of the PERM program. The PERM program is one of several ways that CMS ensures that states make eligibility determinations accurately.
- **Medicaid Eligibility Quality Control (MEQC) Program**. Through the MEQC program, states design and conduct pilots to evaluate their Medicaid and CHIP eligibility processes. In July 2017, CMS issued a final regulation[31] that addressed both MEQC and PERM in an effort to harmonize the approaches, with MEQC focusing on PERM and state identified errors to improve the accuracy of eligibility determinations and reduce improper payments.[32] States have flexibility in designing the pilot programs to focus on error-prone areas within their state eligibility process, which includes both active and negative cases. After the pilot, states will develop CAPs to address identified errors and deficiencies, thus improving the accuracy of their Medicaid and CHIP eligibility processes. On August 29, 2018, CMS released initial guidance[33] to assist states with implementing MEQC pilots. CMS released updated guidance on October 22, 2018.[34]
- **Medicaid Beneficiary Eligibility Reviews.** In 2018, to further support assurances that timely and accurate eligibility determinations are made, CMS began conducting beneficiary eligibility review to confirm if states' Medicaid and CHIP beneficiary eligibility determinations are appropriate and if the federal match is assessed correctly.

- **Streamlining Enrollment: Express Lane Eligibility and Facilitating Enrollment State Plan Option.** Section 3002 of the HEALTHY KIDS Act and section 50101 of the ACCESS Act extended the Express Lane Eligibility (ELE) option, which allows states to use a streamlined process to determine and renew Medicaid or CHIP eligibility for children based

[30] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html?redirect=/PERM02_lawsandregulations.asp

[31] https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicaid-program-and-childrens-health-insurance-program-chip-changes-to-the

[32] https://www.medicaid.gov/medicaid/eligibility/quality-control/index.html

[33] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/subregulatory-guidance-letter-08292018_5.pdf

[34] https://www.medicaid.gov/sites/default/files/2019-12/subregulatory-guidance-10222018.pdf

on information from "express lane agencies," such as the Temporary Assistance for Needy Families, Head Start, and other agencies.[35] CMS continues to encourage states to adopt the use of ELE. CMS also continues to permit states to implement the "Facilitated Enrollment State Plan Option" which allows states to enroll individuals after they have been determined eligible for a different public benefits program, but only when the individuals are certain to be eligible for Medicaid to ensure the integrity of the process. These options have assisted states in streamlining their enrollment processes and ensuring a path to coverage for eligible individuals.

- **MAC Learning Collaborative.** The Learning Collaborative (LCs) provide a forum for facilitated discussion and learning across CMS and states, with the goal of implementing and improving the programs, tools and systems needed to ensure high-performing state health insurance programs. The LCs have served as a critical mechanism for developing, vetting and disseminating promising policy strategies and operational approaches across states. The LCs have also enabled CMS to more effectively identify issues and also monitor and improve program performance while also emphasizing lowering costs. To date, the LCs have contributed to the development of policy guidance, tools and materials. They help CMS craft new models for operating Medicaid and CHIP that will be disseminated and can be adapted by states, whether or not they participated directly in the collaborative process. The LCs have been a valuable forum for identifying states' needs for policy development and clarification. In addition, the LCs have helped encourage peer-to-peer learning between states about promising practices, develop tools to help states build high-performing health programs, and conduct deep policy analysis.
  - **Examples of Activities Undertaken through the Expanding Coverage Under MAC Learning Collaborative**
    - Continuity of Coverage for Former Foster Care Youth: Building on a project focused on ensuring access to Medicaid for former foster care youth, in June 2017, CMS hosted an all-state meeting focused on the specific needs of this population, such as enrollment best practices, and preventing coverage gaps when youth age out of the former foster care eligibility group. A follow-up meeting held in September 2019 provided additional best practices along with strategies for outreach to foster youth and former foster youth.
    - Coverage for Justice Involved Populations: In August 2017, CMS issued a new resource to increase coverage for justice involved populations.[36] This new slide deck builds on 2015 LC work and a 2016 SHO letter with Q&As on facilitating access to Medicaid for eligible individuals before and after time in a correctional institution. The 2017 slides add new content on operationalizing suspension and reclassification to ensure that the federal payment restriction is properly implemented while an individual is incarcerated.

[35] https://www.medicaid.gov/federal-policy-guidance/downloads/sho10003.pdf and https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/sho18010.pdf

[36] https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/justice-involved-populations.pdf

- Eligibility Notices: In August 2017, CMS updated the information and tools to assist states in implementing eligibility-related notice requirements.[37] This included updating the Model Eligibility Notices Toolkit, which was first released in 2013; providing an updated collection of messages that could be included in eligibility-related determination notices; and providing training to states.
- Disaster Toolkit: In August 2018, CMS released a set of tools on the strategies available to support Medicaid operations and enrollees in a time of crises. [38] These tools include a high-level summary of the types of Medicaid and CHIP strategies that can be deployed by states and territories, organized by operational area, and a companion inventory of the strategies available to states and the action needed to effectuate them. These tools serve as a comprehensive disaster preparedness resource for states and territories.
- Enrollment Trends: Also in 2019, CMS launched a Medicaid and CHIP enrollment trends analysis project through the MAC Learning Collaborative. Total national enrollment in Medicaid and CHIP peaked at 75.2 million in May 2017, according to the Eligibility and Enrollment Performance Indicators reported by states. Enrollment declined to 72.4 million by January 2019, a decline of approximately 2.8 million people or 3.7 percent. To better understand the enrollment decline and possible contributing factors, this project has explored the following hypotheses: economic growth and demographic changes; systems issues and operational policies; state eligibility and enrollment policies; and federal policy discourse and development. This project is exploring national trends and conducting a descriptive analysis focused on a sample of 17 states.[39]

- **Activities Undertaken Through the Federally Facilitated Marketplace (FFM) MAC Learning Collaborative**
  - Metrics: The FFM LC team worked collaboratively with CMS to produce an aspirational list of performance and functionality metrics to track whether states' eligibility and enrollment (E&E) systems were performing in accordance with approved provisions. This project helped CMS understand the metrics that states use internally for this purpose. In addition, it was used to advise other states on the usefulness of specific metrics as well as give CMS a sense of whether its list is comparable to those used by states. A component included collecting existing state metrics and comparing and contrasting use across interviewed states.
  - Test Scenarios: In 2019, the LC also developed outcome scenarios for states to test the accuracy of their systems in making non-MAGI determinations. This work included an analysis of the existing tools to help states and CMS measure the accuracy of modified adjusted gross income (MAGI)-based determinations in their new eligibility systems in order to identify how it can be leveraged for non-MAGI

[37] https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/coverage/index.html

[38] https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/medicaid-chip-disastertoolkit.pdf

[39] Performance indicator data is available at: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html

determinations. This work was an important precursor to inform test case development; placing outcome scenario development first and learning some efficiencies that could be practiced will benefit the process for developing test case scenarios.

- Integration: In May 2018, the FFM LC's Health and Human Service Eligibility Integration Data Sharing project helped meet state needs as they sought to integrate health and human service eligibility systems.

B. Efforts to Improve Health Care Quality

HHS has engaged in many significant efforts to improve the quality of health care for children and adults enrolled in Medicaid and CHIP. These efforts are identified across the five domains of care targeted in the Medicaid and CHIP Child and Adult Core Sets: (1) Primary Care Access and Preventive Care; (2) Maternal and Infant Health; (3) Care of Acute and Chronic Conditions; (4) Behavioral Health Care, including prevention and treatment of opioid use disorder; and (5) Dental and Oral Health Services for Children. Many of these efforts include engaging with states through technical assistance, state-to-state sharing and peer learning, and encouraging states to consider using existing policy levers to improve quality of care. In addition, CMS hosts an annual Quality Conference that brings together states and stakeholders and provides an opportunity to share best practices and for states to learn from each other.

1. Efforts to Improve Primary Care Access and Preventive Care

Recognizing that preventing disease before it starts helps people live longer, healthier lives, Medicaid and CHIP help millions of beneficiaries gain access to preventive health care services, including immunizations; screenings for common chronic diseases, infectious diseases, and cancers; clinical and behavioral interventions to manage chronic disease and reduce associated risks; and counseling to support healthy living and self-management of chronic disease.[40] The sections below describe HHS initiatives that aim to improve access to primary care and use of preventive care in Medicaid and CHIP.

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit.** The EPSDT benefit ensures that eligible children from birth to age 21 receive Medicaid coverage for periodic and as-needed screening services to detect any physical and mental health condition. The EPSDT benefit also requires states to make available all medically necessary services covered under section 1905(a) of the Social Security Act in order to correct or ameliorate any physical and mental illnesses and conditions identified through the screening services.[41] Section 12005 of the 21st Century Cures Act (P.L. 114-255) expanded access to the EPSDT benefit for children under age 21 residing in a psychiatric hospital or facility who receive the inpatient psychiatric services for individuals under age 21 Medicaid state plan benefit under section 1905(a)(16)(A) of the Act. The section 1905(a)(16)(A) benefit is considered an exception to the Medicaid prohibition on covering services for persons residing in an institution for mental diseases (IMD).[42] Accordingly, states must cover the EPSDT benefit for

[40] https://www.medicaid.gov/medicaid/benefits/prevention/index.html

[41] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

[42] https://www.medicaid.gov/federal-policy-guidance/downloads/cib062018.pdf

children who reside in a psychiatric hospital or facility and are receiving the section 1905(a)(16)(A) benefit; states must cover the screening, diagnostic, and treatment services provided under EPSDT to these children whether or not these services are provided by the provider of the section 1905(a)(16)(A) services.

- **Medicaid Prevention Learning Network (MPLN).** The MPLN provides an opportunity for state Medicaid programs to engage in 12-month cycles of state-to-state learning and receive enhanced technical assistance on specific areas of prevention.[43] In order to provide comprehensive technical assistance to states and to facilitate exchange of promising practices, CMS has included experts from partner agencies such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the Administration for Children and Families (ACF). Between 2017 and 2019, there have been affinity groups in the areas of antipsychotic drug use in children, HIV health improvement, diabetes prevention and management, and the delivery of Medicaid services in a school setting.
- **From Coverage to Care.** CMS developed the From Coverage to Care (C2C) initiative to help consumers understand their health coverage, including Medicaid, and connect them to the appropriate primary care and preventive services.[44] As a health insurance literacy tool, it educates consumers about the importance of preventive health, and addresses how to engage providers, payers, navigators, coalitions, and community and social service agencies. C2C includes infographics and fact sheets;[45] a guidebook that helps consumers understand their insurance cards, networks, and cost-sharing requirements; a 10-part video series that provides additional advice on "making the most of coverage;"[46] and other resources detailing services available for older adults, women, teens, children, and infants.[47]
- **State Efforts to Expand Coverage of Preventive Services through Medicaid State Plan Amendments (SPAs) and Section 1115 Demonstrations.** Many states have undertaken efforts to expand coverage of preventive services through vehicles such as Medicaid SPAs and section 1115 demonstrations. Examples of state coverage expansions include:
  - Indiana removed the 12-week coverage limitation for tobacco cessation services and also expanded the types of practitioners who can provide nicotine dependence counseling services.[48]
  - Kansas expanded tobacco cessation counseling to all Medicaid beneficiaries.[49]

[43] https://www.medicaid.gov/medicaid/benefits/prevention/resources/index.html

[44] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/get-involved.html

[45] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/from-coverage-to-care.html

[46] https://www.thenationalcouncil.org/capitol-connector/2014/08/coverage-care-new-cms-initiative/

[47] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/from-coverage-to-care.html

[48] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-17-003.pdf

[49] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KS/KS-18-0012.pdf

- Missouri amended the preventive services benefit to remove limitations and amended the tobacco cessation services to pregnant women benefit to remove limitations and expand services to all forms of tobacco use.[50]
- Missouri also added coverage of in-home asthma interventions to help people with asthma improve control of their condition which can reduce preventable emergency department utilization and hospitalizations.[51]
- Maryland added diabetes prevention to the state's section 1115 demonstration. This expanded a pilot initiative with four managed care organizations to a larger population.[52]
- New York and California have approved SPAs to add coverage of diabetes prevention services for people at risk of developing type 2 diabetes.

- **Health Services Initiatives (HSIs).** Under section 2105(a)(1)(D)(ii) of title XXI of the Act and 42 CFR §457.10, states have the option to develop state-designed HSIs that improve the health of low-income and targeted low-income children with unused CHIP administrative funding. States have flexibility in designing their HSI programs, which may include direct services and/or broader educational initiatives, and some states use HSIs to improve access to primary and preventive care. During the reporting period, CMS approved programs to address a broad range of health issues. For example, in May 2017, CMS approved Delaware's HSI to contract with a community-based, non-profit, Medicaid provider to offer vision services and glasses in schools where over half of the student body receives free or reduced-price meals. In October 2017, CMS approved several HSI programs in New Jersey, including a pediatric psychiatric collaborative that provides resources about cases, education, and care coordination. Five states (Indiana, Maryland, Michigan, Ohio, and Wisconsin) have HSI programs to provide lead abatement in homes of low-income children and pregnant women, all of which were approved since 2017. Oklahoma implemented a Reach Out and Read program, which was approved in November 2018 and incorporates books into primary care to improve literacy and developmental screenings. The state also uses HSI funding to provide sickle cell disease care, safe sleep kits, and long-active reversible contraceptive devices. In September 2019, CMS approved Alabama's HSI to provide care coordination services to low-income pregnant women and their infants who are at high risk for pregnancy complications, poor birth outcomes, and infant mortality.
- **CDC's 6|18 Initiative.** Through this initiative, CDC partners with health care providers, public health workers, insurers, and employers to improve health and control health care costs with a focus on six high-burden health conditions and 18 effective interventions that CDC prioritized to improve health and control health care costs.[53] The six focus areas are: reducing tobacco use; controlling high blood pressure; preventing healthcare-associated infections; controlling asthma; reducing unintended pregnancy; and preventing diabetes. As

[50] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MO/MO-18-001.pdf

[51] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MO/MO-16-04.pdf

[52] https://mmcp.health.maryland.gov/Documents/MD%20HealthChoice%20Amendment%20Approval%20(updated%20April%2025,%202019).pdf

[53] Additional information is available at: https://www.cdc.gov/sixeighteen/index.html

part of this initiative, CDC has collaborated with CMS and other partners to provide technical assistance to state Medicaid and public health department teams to implement 6|18 interventions based on states' needs and readiness. Since 2016, 31 state teams have participated in the initiative and have developed or implemented policy changes or other activities to improve access to and quality of care for the target conditions.

- **Childhood Obesity Research Demonstration (CORD).** CORD, a demonstration project overseen by the CDC, funds grantees to improve nutritional and physical activity behaviors of low-income children in a community setting who are struggling with overweight and obesity. CORD 1.0 was funded from 2010-2014 and included four grantees. CORD 2.0 funded two grantees between 2016 and 2018 to focus specifically on children ages 6-12 and the role of health care providers, other health care team members, and community partners for management of childhood obesity in health care and community settings.[54] In CORD 3.0, research teams are focusing on adapting, testing, and packaging effective programs to reduce childhood obesity among children from low-income families. The projects will work towards projects that are sustainable and cost-effective in multiple settings. CORD 3.0 is funding five recipients for 5 years, from 2019 – 2024.[55]

2. Efforts to Improve Maternal and Infant Health

As the largest payer of prenatal care and labor and delivery costs in the United States, Medicaid is uniquely positioned to drive national improvements in maternal and infant health. Medicaid was the principal source of payment for delivery in 42 percent of all U.S. live births in 2018.[56]

Several CMS initiatives have focused on reducing rates of preterm birth and unintended pregnancy. Infants born preterm (before 37 weeks of gestation) and early term (37-39 weeks gestation) have higher morbidity and mortality risks and may endure a lifetime of developmental and health problems when compared to full term infants (39-41 weeks gestation).[57] Unintended pregnancy is associated with poorer preconception health, delayed prenatal care, reduced birth spacing, and increased risks of preterm birth and low birth weight.[58]

Two priority focus areas for CMS are reducing maternal and infant mortality. The number of pregnancy-related maternal deaths reported in the United States is 17 deaths per 100,000 live births in 2017, and has not improved over time.[59] Considerable racial and ethnic disparities in pregnancy-related maternal mortality exist. The reasons for the overall trends and the disparities are not completely understood; however, concerted state efforts may lead to improved outcomes and reduced disparities.[60]

[54] https://www.cdc.gov/obesity/strategies/healthcare/cord2.html

[55] https://www.cdc.gov/obesity/strategies/healthcare/cord3.html

[56] https://www.cdc.gov/nchs/nvss/births.htm

[57] https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf

[58] https://www.medicaid.gov/medicaid/quality-of-care/downloads/maternal-and-infant-health-initiative.pdf

[59] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

[60] https://www.cdc.gov/nchs/products/databriefs/db355.htm

In contrast to maternal mortality, the overall U.S. infant mortality rate has declined over time—from 6.86 infant deaths per 1,000 live births in 2005 to 5.66 in 2018. However, differences by race and ethnicity persist.[61] In addition, 32 countries within the Organization for Economic Co-operation and Development (OECD) report lower infant mortality rates than the overall U.S. rate.[62]

- **Maternal and Infant Health Initiative (MIHI).** In July 2014, CMS announced MIHI, a new initiative to improve maternal and infant health outcomes.[63] The initiative was designed to (1) improve the rate and content of postpartum visits in Medicaid and CHIP, and (2) increase the number of births that are intended. The initiative built on the efforts of CMS's Expert Panel on Improving Maternal and Infant Health Outcomes in Medicaid and CHIP. The Expert Panel was convened to explore program policy and reimbursement opportunities that could result in better care, improve birth outcomes, and reduce the costs of care for mothers and infants in Medicaid and CHIP. Through MIHI, CMS provided technical assistance and materials to states through webinars, such as a webinar that focused on alternative perinatal payment strategies;[64] a technical assistance resource which identified strategies that could improve postpartum care among Medicaid and CHIP populations;[65] and an Informational Bulletin that identified payment approaches used by states to optimize access and use of long-acting reversible contraception.[66]
    - **2019 Maternal and Infant Health Workgroup.** In June 2019, CMS convened a new Maternal and Infant Health Expert Workgroup to accelerate improvements in maternal and infant health. The Workgroup is comprised of both new and returning members from the original Expert Panel. In 2020, this workgroup will (1) make recommendations on how to improve maternal and infant health outcomes for Medicaid and CHIP populations using evidence-based strategies, (2) propose maternal and infant health quality improvement goals for Medicaid and CHIP as well as options for monitoring progress, and (3) recommend resources, data, and other materials to support Medicaid and CHIP agencies' work on quality improvement.
    - **Maternal and Infant Health Initiative Innovation Accelerator Program (MIHI IAP).** In March 2017, IAP launched its MIHI Value-Based Payment (VBP) technical support for Medicaid agencies.[67] Through this technical assistance opportunity, IAP provided technical support to four states to select, design, and test VBP approaches in maternal and infant health over a 2-year period. The four states—Colorado, Mississippi, Maine, and Nevada—received support through tailored coaching and peer-to-peer

[61] https://www.cdc.gov/nchs/data/hus/hus17.pdf

[62] https://data.oecd.org/healthstat/infant-mortality-rates.htm

[63] https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-initiative-fact-sheet.pdf

[64] https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/resources/index.html

[65] https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improve-postpartum-care.pdf

[66] https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf

[67] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/mihi-programoverview.pdf

learning opportunities to lay a foundation for VBP implementation targeted to each state's unique context. The MIHI IAP initiative complements CMS's existing Maternal and Infant Health Initiative, which works with states to explore program and policy opportunities to improve outcomes and reduce the cost of care for women and infants in Medicaid and CHIP.

- **Contraceptive Care Measures**. Historically, a goal of MIHI was to increase access to effective contraception in the Medicaid and CHIP programs. In 2015, CMS awarded grants to Medicaid programs in 13 states and one U.S. territory to support their efforts to collect and report data on new quality measures to assess progress toward this goal.[68] 2019 was the last year of the grant, with 12 states and one territory continuing to participate. The measures were developed by the Office of Population Affairs.

  The Child Core Set for 2020 has the following measures related to contraception:

  - NQF #2902 - Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH); and
  - NQF #2903/2904 - Contraceptive Care – All Women Ages 15 to 20 (CCW-CH).

  The Adult Core Set for 2020 has the following measures related to contraception:

  - NQF #2902 - Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD); and
  - NQF # 2903/2904 - Contraceptive Care – All Women Ages 21 to 44 (CCW-AD).

  These measures provide states and CMS with a way to assess the percentage of Medicaid and CHIP beneficiaries who were at risk of unintended pregnancy or were postpartum and who were provided a most or moderately effective contraceptive method. The contraceptive methods considered most effective are contraceptive implants or intrauterine devices (IUDs), collectively known as long-acting reversible contraception (LARC). Moderately effective contraceptives are injectables, oral pills, patch, ring, or diaphragm.[69] The Contraceptive Care – Postpartum Women (NQF #2902) measure was added to the 2017 Child and Adult Core Sets[70] and the Contraceptive Care – All Women (NQF #2903) measure was added to the 2018 Child and Adult Core Sets.[71]

- **Strong Start for Mothers and Newborns Initiative.** The Strong Start for Mothers and Newborns Initiative, a joint initiative involving CMS, HRSA, and the Administration on Children and Families (ACF) sought to reduce preterm birth and improve outcomes for newborns and pregnant women. From 2013 to 2017, 27 awardees provided enhanced prenatal care services to almost 46,000 women through three approaches: maternity care homes,

[68] https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures

[69] https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

[70] https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf

[71] https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf

group prenatal care, and birth centers.[72] An evaluation found that the birth center participants had preterm birth rates that were 25 percent lower than those in the comparison group. They also had fewer low birthweight infants, cesarean delivery rates, infant emergency department visits, and post-birth hospitalizations. The evaluation compared participants in Strong Start to other women enrolled in Medicaid, with similar demographic characteristics and medical risks (identified in birth certificates and Medicaid claims), and who lived in the same counties but received care in non-Strong Start practices. Regardless of where they gave birth (birth center or hospital) Birth Center participants had costs that were $2,010 lower on average from birth through the first year for each mother-infant dyad. Lower costs for Birth Center participants were likely driven by lower cesarean rates and shorter birth facility (birth center or hospital) stays, with added savings from reduced infant emergency department and hospital utilization in the year following birth. Given these results, CMS has encouraged state Medicaid programs to consider studying the availability of birth center care in their states.[73]

- **CMS Center for Medicare and Medicaid Innovation Center (Innovation Center) Models Addressing Opioid Use Among Pregnant Women:**
  - **Maternal Opioid Misuse (MOM) Model.** In 2019, CMS' Innovation Center announced the MOM Model as part of CMS' multi-pronged strategy to combat the nation's opioid crisis.[74] The model addresses the fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder through state-driven transformation of the delivery system. The MOM model supports the coordination of clinical care and other services critical for health, wellbeing, and recovery in order to improve the quality of care and reduce costs for mothers and infants.[75] Applications for this model were due in May 2019, with ten awardees announced in late 2019: Colorado, Indiana, Louisiana, Maine, Maryland, Missouri, New Hampshire, Tennessee, Texas, and West Virginia. The model's five year performance period began in January 2020.[76]
  - **Integrated Care for Kids (InCK) Model.** The InCK Model, is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children from the prenatal period through age 21 covered by Medicaid and CHIP through prevention, early identification, and treatment of behavioral and physical health needs. This model will empower states and local providers to better address these needs and the impact of opioid addiction through care integration across all types of healthcare providers. This model was also introduced in 2019, with applications due in June 2019. The eight awardees were announced in December 2019: Connecticut, two awardees in Illinois, North Carolina, New Jersey, New York, Ohio, and Oregon. The model's seven year performance period began in January 2020.[77]

[72] https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf

[73] https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf

[74] https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model

[75] https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/

[76] https://www.cms.gov/newsroom/press-releases/cms-awards-funding-combat-opioid-misuse-among-expectant-mothers-and-improve-care-children-impacted

[77] https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/

3. Efforts to Improve the Care of Acute and Chronic Conditions

Chronic diseases are the leading cause of death and disability in the United States, impacting 6 in 10 adults and accounting for 90 percent of the nation's health care expenditures.[78] HHS has undertaken a number of initiatives to improve the care of acute and chronic conditions including efforts to (1) improve diabetes management, (2) promote strategies for non-opioid pharmacologic and non-pharmacologic chronic pain management, (3) address Sickle Cell Disease, and (4) end the HIV epidemic.

- **Diabetes Management.** Proper management of diabetes has the potential to improve health outcomes and prolong life. Between 7.5 percent and 12.7 percent of Medicaid adults ages 18 to 64 have diabetes. The estimated annual per-patient, disease-related costs ranged from $3,219 to $4,674 for diabetes in 2015.[79] Because of the opportunities for diabetes prevention and management, CMS established a Diabetes Prevention and Management Affinity Group to create an interactive forum for state Medicaid agencies to learn from each other and from experts in the field about how to strengthen their programs in both managed care and fee-for-service environments.
- **Strategies for Non-Opioid Pharmacologic and Non-Pharmacologic Chronic Pain Management.** CMS released an informational bulletin in February 2019 that identified Medicaid strategies for non-opioid pharmacologic and non-pharmacologic chronic pain management.[80] The informational bulletin described Medicaid authorities that states may use for coverage of non-opioid pharmacologic and non-pharmacologic pain management therapies, highlighted some preliminary strategies used by several states, and included useful resources to help states consider appropriate pain relief approaches within the context of the national opioid crisis.
- **Sickle Cell Disease Initiative.** Sickle Cell Disease (SCD) affects approximately 100,000 Americans[81] and continues to be a major cause of morbidity and mortality. Given the gravity of the disease, in 2018, HHS convened the HHS Sickle Cell Disease Workgroup to address the transition from pediatric to adult care for this population and to lead efforts to expand data collection. In June 2019, CMS issued a data highlight entitled "Prevalence of Sickle Cell Disease among Medicaid Beneficiaries in 2012."[82] This data brief found that in 2012, 55,349 people enrolled in Medicaid were identified with SCD, most of which were under age 65. CMS also released a SCD indicator in the CMS Chronic Conditions Warehouse in order to support further research.[83] In addition, two awardees of the 2016 four-year Pediatric Quality Measures Program (PQMP) grants are currently testing the feasibility of reporting the two sickle-cell measures developed through the PQMP at the state level. The awardees are working with five state Medicaid programs, an External Quality Review Organization, the

[78] https://www.cdc.gov/chronicdisease/about/index.htm

[79] Am J Prev Med. 2017 Dec; 53(6 Suppl 2): S143–S154

[80] https://www.medicaid.gov/federal-policy-guidance/downloads/cib022219.pdf

[81] https://www.cdc.gov/ncbddd/sicklecell/data.html

[82] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight-16-Sickle-Cell-Disease.pdf

[83] https://www2.ccwdata.org/web/guest/condition-categories

American Academy of Pediatrics, and the Pacific Regional Sickle Cell Collaborative, made up of four western states.

- **Efforts to Reduce the HIV Epidemic**
  - **Ending the HIV Epidemic: A Plan for America.** HIV is a critical public health issue that afflicts more than 1.1 million Americans and costs the government $20 billion in annual direct health expenditures.[84] This initiative will focus on providing the hardest hit communities with additional expertise, technology and resources required to address the HIV epidemic. The goal of the initiative is to reduce new infections by 75 percent in the next 5 years and by 90 percent in the next 10 years.[85]
  - **HIV Health Improvement Affinity Group.** In 2016, CMS partnered with CDC and HRSA to launch the HIV Health Improvement Affinity Group, which brought together state public health, Medicaid, and CHIP agencies to collaboratively work to improve rates of sustained virologic suppression among Medicaid and CHIP beneficiaries living with HIV.[86] An evaluation of the outcomes of the affinity group showed that of the 19 states participating, 13 established data sharing agreements between Medicaid/CHIP and public health agencies; 12 successfully matched data between or streamlined the data matching process; 8 generated an HIV care continuum for state Medicaid/CHIP beneficiaries; and 6 began quality improvement initiatives.[87]

4. Efforts to Improve Behavioral Health Care

Medicaid is the nation's largest payer of behavioral health services, financing roughly one-quarter of all spending for both mental health services and SUD treatment. In the Behavioral Health Spending and Use Accounts, 2006-2015, report, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that in 2015, $156 billion was spent on mental health services and $56 billion for substance use disorders.[88] Medicaid and CHIP pay a substantial share of health care costs for those addicted to opioids. According to the National Survey on Drug Use and Health, 42.8 percent of non-elderly adults with opioid use disorder (OUD) were covered by Medicaid or CHIP in 2019.[89] CMS has undertaken significant efforts to address SUDs, particularly in the areas of opioid use disorder; other SUDs; serious mental illness (adults) and serious emotional disturbance (children); and physical and behavioral health integration.

- **Efforts to Improve the Delivery System.** Section 1115 demonstrations give states flexibility to address SUDs identified within their Medicaid populations, and to phase in state-specific

[84] https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

[85] https://www.hhs.gov/blog/2019/02/05/ending-the-hiv-epidemic-a-plan-for-america.html

[86] https://www.medicaid.gov/sites/default/files/2019-12/hiv-affinity-group-fact-sheet.pdf

[87] https://www.cdc.gov/hiv/pdf/library/reports/cdc-hiv-affinity-group-evaluation-report-2019.pdf

[88] https://store.samhsa.gov/sites/default/files/d7/priv/bhsua-2006-2015-508.pdf

[89] https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases

solutions over time.[90] Through an initiative announced in November 2017, CMS is partnering with states on demonstrations to improve access for Medicaid beneficiaries to the full continuum of SUD treatment including outpatient; intensive outpatient; medication assisted treatment (MAT); and residential and inpatient care in specialized settings that are generally excluded from Medicaid due to the IMD exclusion.[91] Participating states are expected to take specific steps to improve quality of care for beneficiaries with OUD or other SUDs, for example, by implementing requirements that residential treatment facilities provide access to MAT as well as other provider qualifications reflecting nationally recognized SUD program standards. In addition, participating states are expected to take actions to increase access to SUD providers, improve care coordination, and implement use of evidence-based assessment criteria to ensure beneficiaries are receiving treatment in appropriate levels of care. Twenty-eight section 1115 demonstrations related to SUD have been approved, with 25 approved between 2017 and 2019. As part of the demonstration process, CMS is providing technical assistance to states, as well as continuously monitoring and evaluating each demonstration using, where possible, a set of standardized metrics. Examples of section 1115 SUD demonstrations include:

- **Alaska's Substance Use Disorder and Behavioral Health Program**. This demonstration, which was approved in November 2018, targets children, adolescents, and adults with or at risk of mental health and SUDs. It aims to provide a continuum of SUD services by increasing benefits and using evidence-based SUD program standards. It will also increase capacity by building provider networks across the state.[92]
- **West Virginia's Creating a Continuum of Care for Medicaid Beneficiaries with Substance Use Disorders.** Approved in October 2017, this demonstration strengthens the SUD delivery system for Medicaid beneficiaries through expanded SUD coverage and new programs targeted at improving quality of care.[93] It expands SUD benefits to cover the full continuum of SUD treatment, including methadone treatment, short-term residential treatment services, peer recovery support services, and withdrawal management services.
- **Delaware's Diamond State Health Plan Extension.** On July 31, 2019, CMS approved a 5-year demonstration extension authorizing Delaware to receive federal financial participation (FFP) for expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an IMD.[94] Delaware plans to improve outcomes for Medicaid beneficiaries experiencing SUD by maintaining and enhancing access to SUD

[90] https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/substance-use-disorders/1115-substance-use-disorder-demonstrations/index.html

[91] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[92] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/80966

[93] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-beneficiaries-substance-fs.pdf

[94] https://www.doverpost.com/news/20190805/dhss-receives-medicaid-substance-use-disorder-waiver-from-federal-government

services, including inpatient and residential SUD services in settings that qualify as an IMD. The OUD/SUD benefits provided under the demonstration are Medicaid state plan services. Under the demonstration, the state will have the authority to receive FFP for SUD services as described in the Delaware Medicaid State Plan when provided to beneficiaries residing in IMDs for short-term stays primarily to receive SUD treatment.

- **Overview of Substance Use Disorder Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms.** Together with the American Society of Addiction Medicine, CMS developed a resource to support state efforts to introduce SUD service coverage and delivery system reforms by providing information about the preventive, treatment, and recovery services and the levels of care comprising the continuum of SUD care.[95] The document provides an overview of national guidelines for SUD treatment criteria, including provider and service standards for each level of care, and examples of state-based initiatives that provide industry-standard SUD treatment appropriate for each Medicaid beneficiary.
- **Medication-Assisted Treatment (MAT) Clinical Pathway and Rate Design Tool.**[96] In 2017, CMS released a toolkit for states interested in developing a payment rate for MAT with buprenorphine to treat OUD. CMS developed a rate design tool that reflects the costs of providing the clinical services in each model by constructing a clinical pathway corresponding to each MAT service delivery model; identifying distinct phases of treatment; and delineating the sites, types, and time requirements of professional staffing for each phase.
- **MAT Roundtables.**[97] From March to September 2019, CMS held virtual MAT Roundtables to provide opportunities for states to review: (1) key MAT practices and (2) methods used to expand and/or modernize MAT provider delivery strategies for SUD treatment, particularly OUD in Medicaid. Using a point-counterpoint format, the roundtables addressed how states can use these strategies in their Medicaid programs.
- **Opioid Specific Initiatives:**
  - **Leveraging Medicaid Technology to Address the Opioid Crisis.**[98] In a 2018 letter to State Medicaid Directors, CMS provided guidance to states on the funding authorities for health information technology strategies that could help combat the OUD crisis. Strategies discussed in this guidance include prescription drug monitoring programs, advanced analytics and public health data, technologies for coordinating care and increasing access to care (such as telehealth), and enhanced statewide interoperability. CMS identified how states could leverage existing funding authorities to support such efforts.

[95] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf

[96] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/mat-overview.pdf

[97] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/mat-roundtables-program-overview.pdf

[98] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf

- **Opioid Data Analytics Cohort.**[99] CMS supported 12 states in the initial stages of examining their SUD data, with a particular focus on OUD, MAT, NAS, and OUD care for pregnant women enrolled in Medicaid. Participation was geared toward states in the early stages of conducting analyses to size and stratify their opioid problem, assess the distribution and availability of MAT, and understand the size and characteristics of NAS and opioid-related maternity care in Medicaid.
- **Opioid Data Dashboards Flash Track.**[100] This short course helped six states produce a data dashboard, a plan for a dashboard, a prototype, or a mock-up for a section of a dashboard on opioids in their Medicaid program. The Opioid Data Dashboards Flash Track addressed questions around how to construct and use a data dashboard; provided ongoing technical support and facilitated state-to-state discussions to share progress and challenges; and shared examples of data dashboards produced by other states.
- **Medicaid State Opioid Prescribing Mapping Tool.**[101] CMS and HHS developed this interactive tool, which shows state-level geographic comparisons of de-identified Medicaid opioid prescriptions filled within the United States in 2017, to help increase awareness of OUD among providers and state and local health officials. The mapping tool allows users to see both the number and percentage of opioid prescriptions in order to better understand how this critical issue impacts states nationwide.
- **Efforts to Address Opioid Use During Pregnancy.** Pregnant women who misuse substances are at high risk for other adverse outcomes, including preterm labor and delivery complications and postpartum women with OUD are at highest risk of overdose.[102] Infants exposed to opioids before birth are also at increased risk of negative outcomes, such as being born preterm, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome. Neonatal abstinence syndrome is a constellation of clinical symptoms in newborn infants exposed to any of a variety of substances in utero; however recent increases in neonatal withdrawal most commonly result from exposure to opioids.[103] The incidence of NAS among infants covered by Medicaid increased more than five-fold between 2004 and 2014, from a rate of 2.8 per 1,000 births to 14.4 per 1,000 births.[104] Medicaid pays the largest portion of hospital charges for maternal substance use, as well as a majority of the $1.5 billion annual cost of NAS.[105]

[99] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/sud-program-overview.pdf

[100] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/sud-program-overview.pdf

[101] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap_Medicaid_State.html

[102] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6060005

[103] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf

[104] https://pediatrics.aappublications.org/content/141/4/e20173520

[105] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5869343/

In June 2018, CMS released an Informational Bulletin to provide states with guidance around treating infants with NAS. The Informational Bulletin discussed strategies for states to consider to improve health outcomes for infants with NAS.[106] Prior to the release of the Informational Bulletin, West Virginia submitted a SPA, approved in February 2018 that pays an all-inclusive rate for NAS treatment professional services, as well as ancillary costs directly related to the provision of these services (but excluding room and board).[107] As part of its multi-pronged strategy to combat the nation's opioid crisis, CMS announced two Innovation Center models focused on pregnant and postpartum women and children: Integrated Care for Kids (InCK) Model and Maternal Opioid Misuse (MOM) Model.

- **State Guidance for Implementation of Medicaid Drug Utilization Review (DUR) Provisions Designed to Reduce Opioid Related Fraud, Misuse and Abuse.** On August 5, 2019, CMS issued guidance to states regarding implementation of the new Medicaid DUR provisions under section 1004 of the SUPPORT Act designed to reduce opioid related fraud, misuse and abuse. This provision establishes new requirements regarding opioid prescription claim reviews at the point of sale and retrospective reviews; monitoring and management of antipsychotic medication in children; identification of processes to detect fraud and abuse; and mandatory DUR report updates.[108]
- **Efforts to Address Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED).** As mandated by section 12003 of the 21st Century Cures Act, CMS provided guidance to states in November 2018 announcing opportunities for states to design innovative service delivery systems for adults with SMI or children with SED who are receiving medical assistance.[109] This letter describes a number of evidence-based models and best practice strategies that can be supported by existing Medicaid authorities. It also established a new demonstration opportunity focused on improving care for beneficiaries with SMI or SED. Similar to the demonstration opportunity focused on SUD treatment, through this initiative, CMS will partner with states on demonstrations designed to improve access to a continuum of care for Medicaid beneficiaries with SMI or SED including outpatient care, and crisis stabilization. It also includes access to psychiatric hospitals and specialized residential treatment settings that qualify as IMDs and are traditionally excluded from Medicaid.[110] The evidence-based models, best practices, and demonstration opportunity included in the guidance are focused on encouraging states to address a number of high priority issues including the need for earlier identification and engagement of individuals with SMI or SED in treatment, increased integration of mental health care into non-specialized settings, improved access to services across a continuum of care including crisis stabilization services, and the need for improved care coordination and transitions to community-based care. Participating states must report information on steps taken to address

[106] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf

[107] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WV/WV-17-004.pdf

[108] https://www.medicaid.gov/federal-policy-guidance/downloads/cib080519-1004.pdf

[109] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

[110] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

these issues as well as data and performance measures identified by CMS as key indicators of progress. States will also have to conduct rigorous evaluations.

- **Efforts to Promote Physical Health and Behavioral Health Integration.** Medicaid beneficiaries with behavioral health issues often have substantial physical health needs as well. Within the non-dually eligible adult Medicaid population, beneficiaries with behavioral health diagnoses are more likely to have multiple concurrent chronic medical conditions than beneficiaries without a behavioral health diagnosis.[111] From April 2016 to April 2017, the Medicaid Innovation Accelerator Program (IAP) provided technical assistance to nine state Medicaid agencies and resources to assist them with physical and mental health integration efforts. Drawing on lessons learned in working with these nine states, IAP hosted four national dissemination webinars between July 2017 and March 2018.[112] IAP also developed a factsheet that describes policy levers that states can use to help providers engage in physical and mental health integration and provides state examples:[113]

5. Efforts to Improve Dental and Oral Health Services

Tooth decay remains one of the most common chronic diseases among children, despite it being preventable. Approximately 46 percent of children ages 2 to 19 have or have had dental caries in their primary or permanent teeth. There is variation among age groups, from 21.4 percent among children ages 2-5, to 50.5 percent among children ages 6-11, to 53.8 percent among children ages 12-19.[114] States are required to provide comprehensive dental benefits to children enrolled in Medicaid and CHIP, including oral health services such as dental exams, cleanings, and any services deemed as medically necessary. Given that oral health is essential for overall health, continuing to improve access to and use of oral health services by children in Medicaid and CHIP remains a CMS priority.

- **Children's Oral Health Initiative (OHI).** In 2010, CMS launched the Children's Oral Health Initiative (OHI), seeking to increase by at least 10 percentage points the proportion of children ages 1 to 20 enrolled in Medicaid or CHIP who receive a preventive dental service.[115] CMS's support for states under the OHI and related initiatives resulted in a 6 percentage point improvement in the delivery of preventive dental services from a baseline rate of 42 percent in FFY 2011 to a rate of 48 percent in FFY 2018.[116] Two examples of states that achieved substantial gains included:

[111] https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program percentE2 percent80 percent94People-Use-and-Expenditures.pdf

[112] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/physical-and-mental-health-integration/index.html

[113] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/iap-strategies-for-promoting-provider-capacfity-factsheet.pdf

[114] https://www.cdc.gov/nchs/data/databriefs/db307.pdf

[115] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-10-2014.pdf

[116] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-chart-pack.pdf

- Florida pursued improvement strategies focused on the delivery of dental services to children enrolled in Medicaid managed care organizations (MCOs).[117] By FFY 2017, the proportion of children in Florida ages 1-20 receiving a preventive dental service increased 18 percentage points since the FFY 2012 baseline.[118]
- California received CMS approval for an 1115 demonstration in 2015 to implement its Dental Transformation Initiative (DTI) aimed at increasing the delivery of dental services, especially preventive dental services, to enrolled children ages 1-20. By FFY 2017, the proportion of children in California receiving a preventive dental service increased by 8 percentage points from the FFY 2014 baseline.[119]

Recognizing the need for ongoing improvement, CMS launched the Oral Health Initiative 2.0 (OHI 2.0) in 2017. OHI 2.0 sought to accelerate progress on access to oral health care by (1) conducting assessments to identify components of high-performing delivery systems; (2) spreading what works; (3) reviewing assessment of progress with state Medicaid leadership; (4) engaging states to develop and agree on improvement targets and strategies; (5) documenting the agreement on improvement targets and strategies where appropriate; and (6) encouraging states to take action. As part of its technical assistance efforts, CMS continues to engage state Medicaid and CHIP representatives through the monthly Oral Health Technical Advisory Group calls to share best practices and help states address challenges.

In March 2017, Medicaid IAP selected three Medicaid agencies to participate in the Children's Oral Health Initiative (OHI) Value-Based Payment (VBP) technical support opportunity— IAP provided technical assistance to the District of Columbia, Michigan, and New Hampshire—with selecting, designing, and testing VBP approaches to sustain care delivery models that demonstrate improvement in children's oral health outcomes.[120] The states received technical assistance over two years through tailored coaching and peer-to-peer learning opportunities to lay a foundation for VBP implementation targeted to each participant's unique context.

CMS issued an informational bulletin in March 2018 that addressed the importance of proper implementation of states' pediatric dental periodicity schedules. CMS indicated that Medicaid and CHIP programs should align their dental payment policies and periodicity schedules to ensure that payment is available for recommended dental care. Additionally, CMS reminded states that the periodicity schedule should be treated as a "floor" and not a "ceiling" for coverage of dental services and that there should be a payment mechanism for medically necessary services that exceed the periodicity schedule. [121]

[117] https://ahca.myflorida.com/Medicaid/recent_presentations/October_2017/House_HHS_Dental_Quality_Scores_and_Procurement_Update__Final_102317.pdf

[118] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

[119] https://www.dhcs.ca.gov/Documents/MDSD/DTI_PY2_Final_Report_12-27-18_2.0.pdf

[120] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/value-based-payment/index.html

[121] https://www.medicaid.gov/federal-policy-guidance/downloads/cib050418.pdf

Because CMS recognizes that there continues to be a need for further improvement in the use of preventive dental services by children enrolled in Medicaid and CHIP, CMS is committed to continuing the OHI and working with states to improve their performance.

While improving oral health for children has been a major focus of CMS's work, CMS continues to support efforts to increase access to dental services for adults. States have the option of providing a dental benefit for adults in Medicaid; most states provide at least emergency dental services and less than half provide comprehensive dental care to adults. CMS provides technical assistance to help states design dental benefits for adults.

C. Levers that Support State Quality Efforts

There are many different mechanisms at both the state and Federal level that support efforts to improve Medicaid quality across all dimensions. These levers include grants to states, technical assistance and the delivery of care.

1. Medicaid and CHIP Scorecard

In June 2018, CMS launched the MAC Scorecard to increase public transparency and accountability about the programs' administration and outcomes. The Medicaid and CHIP Scorecard displays Medicaid and CHIP quality measures with federally reported measures across three areas: State Health System Performance, State Administrative Accountability, and Federal Administrative Accountability.[122] The quality measures cover such topics as postpartum care, well-child visits, immunizations, managed care capitation rate review, state plan amendments, and section 1115 demonstrations. States are encouraged to use data from the Medicaid and CHIP Scorecard to implement improvements in state and federal alignment, health outcomes, program integrity and program administration.[123] CMS refreshed the MAC Scorecard in July 2019 with an updated national context section and FFY 2017 state health system performance pillar data. The November 2019 update included 8 new measures within the area of State Health System Performance and 5 new measures in the area of State Administrative Accountability, as well as many new National Context data points. In addition, Scorecard navigation was improved, with interactive features that allow users to sort certain measures by performance rates.[124]

2. Transformed Medicaid Statistical Information System (T-MSIS)

Since 2014, CMS has been working with states to transform the Medicaid Statistical Information System (MSIS), which was used to collect utilization and claims data and other key Medicaid and CHIP program information. This transformation was necessary to assess beneficiary care and enrollment, improve program integrity, and support states, the private market, and stakeholders with key information. The T-MSIS data set contains detailed information about Medicaid and CHIP eligibility, beneficiary and provider enrollment, service utilization, fee-for-service and managed care data, and expenditures.[125] The availability of high-quality, timely T-

[122] https://www.medicaid.gov/state-overviews/scorecard/index.html

[123] https://www.medicaid.gov/state-overviews/scorecard/index.html

[124] https://www.cms.gov/newsroom/fact-sheets/2019-medicaid-and-chip-mac-scorecard

[125] https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html

MSIS data for all states is essential to support advanced analytics and ensure robust monitoring and oversight of Medicaid and CHIP programs.

CMS has focused considerable efforts not only on integrating state Medicaid data into T-MSIS, but also partnering with states to monitor data integrity reviews to ensure accuracy and completeness of monthly T-MSIS data submissions.[126] As of July 2019, 50 states, the District of Columbia, and two territories (Puerto Rico and Virgin Islands) submit monthly data to T-MSIS.[127]

3. Managed Care

As of July 1, 2017, approximately 82 percent of all Medicaid beneficiaries were enrolled in some form of managed care with over 69 percent receiving care through a comprehensive managed care plan.[128] In addition, 33 states provide separate CHIP coverage through managed care arrangements. States using a managed care delivery system for all or some of their Medicaid and CHIP beneficiaries must comply with certain federal requirements, which include monitoring the quality of care provided by contracted managed care plans.

The May 2016 Medicaid and CHIP Managed Care Final Rule[129] included a number of revisions to the managed care quality provisions for Medicaid and CHIP managed care programs. The most notable changes were: extending the existing quality provisions to prepaid ambulatory health plans (PAHPs) and certain primary care case management (PCCM) entities; establishing authority for CMS to develop a quality rating system (QRS) for Medicaid and CHIP plans that states are required to either adopt, or use an alternative, substantially comparable quality rating system that must be approved by CMS; and several provisions aimed at increasing transparency and public reporting of plan accreditation status, state quality strategies, and external quality review reports. In a November 2018 Notice of Proposed Rulemaking (NPRM),[130] CMS also proposed several additional clarifying and technical changes related to transparency and public posting of quality information and several changes to the regulatory authority for the QRS. The managed care final rule was published in November 2020[131] and finalized many of the policies largely as proposed.[132] In addition, rulemaking for the QRS will be forthcoming.

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[126] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO18008.pdf

[127] https://www.medicaid.gov/federal-policy-guidance/downloads/cib031819.pdf

[128] https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf

[129] 81 FR 27498, May 6, 2016

[130] 83 FR 57264, November 14, 2018

[131] 85 FR 72754, November 13, 2020

[132] In summary, the November 2020 final rule added a requirement that CMS develop a minimum set of mandatory performance measures as part of the MAC QRS framework that must be implemented by a state at a future date; expanded the scope of alignment of the MAC QRS and this minimum measure set with the Medicaid Scorecard initiative and other CMS managed care rating systems (such as the Quality Star Rating system for Medicare Advantage); made explicit CMS' intention to take feasibility into consideration when assessing whether an alternative state QRS produces substantially comparable information to that yielded by the CMS-developed QRS; made explicit CMS' intention to consult with states and other stakeholders in developing the MAC QRS.

- **Quality Strategy.** States are required to maintain a managed care quality strategy that serves as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting measurable goals and targets for improvement.[133] States are required to complete a review of their managed care quality strategy at least every three years, which includes assessing the effectiveness of the quality strategy. States are also required to review and update the managed care quality strategy as needed, but no less than once every three years. States are required to submit their quality strategy to CMS for review and feedback and to post the effectiveness evaluations and revised quality strategies on their state Medicaid website.
- **Quality Assessment and Performance Improvement (QAPI) Program.** States must require, through their managed care contracts, that every MCO; prepaid inpatient health plan (PIHP); and prepaid ambulatory health plan (PAHP) implement an ongoing and comprehensive QAPI program.[134] Some elements of QAPI also apply to certain PCCM entities whose contracts provide for shared savings, incentive payments or other financial reward to the PCCM entity for improved quality outcomes. The QAPI must include performance improvement projects (PIPs); collection and submission of performance measurement data; mechanisms to detect over- and underutilization of services; and mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
    - **PIPs.** States are required to ensure through managed care contracts that MCOs, PIHPs, and PAHPs undertake PIPs in both clinical and nonclinical areas that are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.
    - **Performance Measurement.** States are required to identify standard performance measures relating to the performance of MCOs, PIHPs and PAHPs. Each MCO, PIHP and PAHP is required to annually measure and report on its performance to the state Medicaid agency. They are also required to submit data which allows the state to calculate the MCO, PIHP or PAHPs performance using the standard measures identified by the state.[135]
- **External Quality Review (EQR).** States are required to provide for an annual independent EQR of MCOs, PIHPs, PAHPs, and certain PCCM entities. Qualified external quality review organizations (EQROs) analyze and evaluate information on the quality, timeliness, and access to health care services provided annually by managed care plans and their contractors.[136] The EQRO produces an annual EQR report, which provides detailed analysis of the strengths and weaknesses of each managed care plan and makes recommendations for

[133] 42 CFR § 438.340

[134] 42 CFR § 438.330

[135] 42 CFR §438.330(c)

[136] Consistent with section 1932(c) of the Act, federal regulations implemented in 2003 and updated in 2016 require states to perform an annual EQR for managed care plans. Prior to the publication of the May 2016 final rule, EQR was required for MCOs and PIHPs. The 2016 final rule extended EQR requirements to PAHPs and certain PCCM entities; that final rule required compliance by states with the expanded EQR requirements no later than July 1, 2018. (81 FR 27499 and 42 CFR 438.310(d)(2); 42 CFR 438.350 through 438.364)

improvement. States must post the annual EQR reports on the state Medicaid website. The state, its agent (that is not a managed care plan entity), or an EQRO must perform four mandatory EQR-related activities, which provide the information for the EQR:[137]

1. Validation[138] of performance measures
2. Validation of performance improvement projects (PIPs)
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
4. Validation of network adequacy[139]

A state may also choose to perform up to six optional EQR-related activities.[140] A set of EQR protocols provide instruction to states and EQROs on the process for conducting each of the ten EQR-related activities.[141] Sections 1139A and 1139B require HHS to report annually on information that states collect through EQRs.[142] HHS publishes tables highlighting findings for performance measurement and performance improvement projects activities in EQR. These tables are posted to Medicaid.gov annually by September 30th.[143]

[137] 42 CFR §438.358(b)(1)(i)–(iv)

[138] 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 accordance with standards for data collection and analysis.

[139] The May 2016 final rule added a new mandatory activity for validation of network adequacy, §438.358(b)(1)(iv). States must begin conducting the EQR-related activity relating to validation of network adequacy no later than one year from the issuance of the associated EQR protocol. 81 FR 27499. The development of the protocol has been in process and CMS is expected to post the proposed protocol for comment in 2021 under the Paperwork Reduction Act process.

[140] 42 CFR §438.358(c)(1)-(6). For each MCO, PIHP, PAHP, and PCCM entity, six additional, optional EQR activities may be performed.

[141] Section 1932(c)(2)(ii) of the Act provides that the Secretary, in coordination with the National Governors' Association, must contract with an independent quality review organization to develop the protocols. In October 2012, CMS revised the EQR Protocols for the purpose of standardizing and strengthening managed care quality monitoring and improvement activities in Medicaid. The CMS EQR Protocols are available under "Technical Assistance Documents" at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. CMS revised the EQR protocols in 2019 to address changes in the 2016 Medicaid and CHIP managed care final rule, which aligns several appeals rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections.

[142] Section 1139A(c)(1)(B) of the Social Security Act requires HHS to annually report on the quality of health care furnished to children including information that states collect through EQRs. Section 1139B(d) requires HHS to annually report on the quality of health care furnished to adults including information that states collect through EQRs. 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, PIHPs, PAHPs and certain PCCM entities. In other words, state EQR technical reports must include information related to benchmark plans that deliver care through these plans; however, because this information is reported in the aggregate, which is allowable under EQR requirements, detailed data are not available for benchmark plans.

[143] https://www.medicaid.gov/medicaid/quality-of-care/downloads/2018-2019-chart-pack.zip

Beginning July 1, 2018, MCOs, PIHPs, PAHPs, and CHIP plans are required to undergo all four EQR-related activities, while PCCM entities are required to undergo only two of the mandatory activities (a compliance review and validation of performance measures).[144] The state may also choose to perform up to six optional EQR-related activities, such as the validation of encounter data.[145] EQR protocols provide instruction to states and EQROs on the process for conducting each of the 10 mandatory and optional EQR-related activities.

4. State Plan Amendments (SPAs) and Demonstrations

- **Timely and Accurate SPA and 1915 Waiver Application Processing**. In 2017, CMS launched an initiative to engage with states to make the SPA, 1915(b), and 1915(c) waiver approval processes more transparent, efficient and less burdensome. After consulting with states and other stakeholders, CMS developed strategies to streamline the process and provided tools for states to use in the development of SPA and 1915 waiver submissions.[146] As a result of these efforts:
    - Between 2016 and 2018 there was a 16 percent decrease in the median approval time for Medicaid SPAs.
    - Seventy-eight percent of SPAs were approved within the first 90 day review period during calendar year 2018, a 14 percent increase over 2016.
    - Between calendar year 2016 and 2018, median approval times for 1915(b) waivers decreased by 11 percent, 1915(c) renewal approval times decreased by 38 percent, and 1915(c) amendment approval times decreased by 28 percent.
    - The backlog of pending SPA and 1915 waiver actions pending additional information from the states was reduced 80 percent from previous years.[147]
- **SPAs**. Each state has Medicaid and CHIP state plans, which are agreements between the state and the federal government describing how the state administers its Medicaid and CHIP programs. States have flexibility to design their own programs within federal guidelines. Through SPAs, states specify what services are provided to what populations. Beginning in 2017, CMS implemented a strategy to increase transparency, enhance efficiency, and reduce burden for states in the review and approval process of SPAs. CMS has worked with states to ensure that process improvement activities were comprehensive and responsive to state needs.
- **1915(b) Waivers.** States use authority under section 1915(b) of the Social Security Act to implement managed care delivery systems. These waivers are used to restrict Medicaid enrollees from receiving services within the managed care network (Freedom of Choice); utilize a central broker (Enrollment Broker); use cost savings to provide additional services to beneficiaries (Medicaid services waiver) and restrict the providers from which Medicaid

[144] 42 CFR 438.310(d); 42 CFR 438.258(b)(2).

[145] These six optional activities are codified at §438.358(c).

[146] https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html

[147] https://www.cms.gov/blog/cms-streamlines-medicaid-review-process-and-reduces-approval-times-so-states-can-more-effectively

eligible beneficiaries may obtain services from (selective contracting waiver).[148] The approval period for a 1915(b) waiver is two years. As stated above, 1915(b) waivers are included in CMS' efforts to improve timely and accurate SPA and waiver processing.

- **1915(c) Waivers.** Within broad Federal guidelines, states can used the authority under section 1915(c) of the Social Security Act to develop home and community-based services waivers to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. 1915(c) waivers allow states to waive certain Medicaid program requirements including statewideness, which allows states to target certain areas of the state where the need is greatest or types of providers are available; comparability of services which allows states to make services available only to certain groups of people who are at risk of institutionalization; and income and resource rules which allows states to provide Medicaid to people who would otherwise only be eligible in an institutional setting.[149] 1915(c) waivers are also included in CMS' efforts to improve timely and accurate SPA and waiver processing.
- **Section 1115 Demonstrations.** Section 1115 demonstrations give states flexibility to make certain changes to their Medicaid programs if HHS determines the changes are likely to assist in promoting the objectives of the Medicaid statute. In order to increase flexibilities and reduce burden to states, significant efforts were undertaken to improve the review, approval, monitoring and evaluation of section 1115(a) Medicaid demonstrations.[150]

  Working closely with states, CMS provided technical assistance to support state efforts in their designs of innovative programs, benefits, and services through section 1115 demonstrations aimed at expanding coverage and improving health outcomes for Medicaid beneficiaries. This included working with states to improve the availability and quality of services to address social determinants of health; reducing disparities in the healthcare system; expanding treatment options for people with SUD and SMI; strengthening integration of physical and mental health; aligning provider incentives across payers; and advancing value-based care.

  CMS has also increased the rigor associated with state-submitted monitoring and evaluation deliverables by working closely with states, providing one-on-one technical assistance, and clearly identifying expectations of states. This effort began in 2016, and all demonstrations approved during or after 2017 included Special Terms and Conditions holding states to a higher level of accountability for quality monitoring and evaluation, to improve understanding and for diffusion of best practices. In that same spirit, CMS conducted federal evaluations of several types of section 1115 demonstrations, including demonstrations intended to improve value of care through provider incentive payments; use of LTSS in managed care versus fee-for-service; and alternative approaches to coverage expansion.

  Between 2017 and 2019, CMS approved 1115 demonstrations that test the:

[148] https://www.medicaid.gov/medicaid/managed-care/authorities/index.html

[149] https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html

[150] https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf

- Alignment of payment incentives with performance and quality measures for improved health outcomes;[151]
- Provision of case management/care coordination, tenancy supports, one-time transition costs, non-medical transportation, home delivered meals, supported employment, or other state-defined direct services to address social determinants of health such as food and housing insecurity;[152]
- Use of integrated community-based partners, including behavioral health and social service community partners, to provide care coordination for members with complex behavioral and long-term services and supports (LTSS) needs;[153] and
- Advancement of comprehensive treatment for members with SUD and SMI.[154]

In addition, CMS approved 1115 demonstrations that focused on the following two areas:

- **Maternal Health.** Section 1115 demonstrations were approved that extend the duration of Medicaid eligibility for pregnant women beyond the 60-day postpartum period to provide a benefit of family planning and/or related preventive women's health services, or to implement other state-based initiatives aimed at improving maternal health outcomes. Through this initiative, states can test a broad range of multi-disciplinary approaches to post-pregnancy service delivery and connect women to needed social services. Examples of expanded coverage and services included providing extended postpartum coverage period beyond the 60-day state plan coverage limit for pregnant women and women with SUD; targeted case management services; home visiting services; and specialty services for women who deliver a low birthweight baby.[155]
- **Address Health Crisis.** Section 1115 demonstration authority has been leveraged to address existing health crises. The SUD Initiative and the SMI and SED Initiative, addressed earlier, are examples of initiatives that were designed to provide states flexibility to address existing health crises. These demonstrations expanded coverage and the availability of a comprehensive range of services, including MAT. In addition, they tested approaches to better target needed services; addressed social determinants of health; and integrated behavioral and physical health service delivery.

5. Medicaid Innovation Accelerator Program (IAP)

CMS established the Medicaid IAP in 2014 to improve the care and health of Medicaid beneficiaries and to reduce costs by supporting states' ongoing service delivery and payment reforms through targeted technical assistance.[156] As of April 2019, IAP has engaged with all 50

[151] See for example California Medi-Cal 2020 Section 1115 Demonstration

[152] See for example North Carolina Medicaid Reform Demonstration, Maryland Health Choice Demonstration

[153] See for example MassHealth Section 1115 Demonstration

[154] See list of CMS approved SUD/SMI section 1115 demonstrations: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html

[155] See for example Georgia Planning for Healthy Babies, Maryland Health Choice Demonstration, Illinois Behavioral Health Transformation

[156] https://innovation.cms.gov/initiatives/MIAP/

states and the District of Columbia through its web-based learning series and national dissemination webinars. IAP has also worked with 40 states, three territories, and the District of Columbia through direct technical support opportunities. Of those, half of the states participate in three or more technical assistance opportunities.

IAP works closely with state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities in four program areas that were identified as having technical assistance gaps. Those areas include: reducing substance use disorders; improving care of Medicaid beneficiaries with complex needs and high costs; and promoting community integration through long-term services and supports. Each of these areas represents a separate, sometimes multi-tiered technical support program for states to improve how care is delivered for these populations. As part of the IAP's efforts to support ongoing Medicaid delivery system reforms, targeted technical support and tools are also offered to states in areas such as: data analytics, performance improvement, and payment modeling and financial simulations. Through these functional areas, IAP provides support to states individually or through the development of tools.

6. Medicaid Health Homes

Medicaid health homes (under section 1945 of the Act) provide care management, care coordination, patient and family support, and certain other related services that help to coordinate and integrate primary, acute, behavioral, and long-term care services and supports for certain Medicaid beneficiaries. To be eligible for health home services under section 1945 of the Act, a beneficiary must have at least: two chronic conditions; one chronic condition and be at risk for a second; or one serious and persistent mental health condition. Chronic conditions include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions such as HIV may be considered for approval.[157]

CMS requests that states report annually on core set measures for all section 1945 health home programs. In 2019, these measures were: (1) initiation and engagement of alcohol and other drug misuse or dependence treatment, (2) controlling high blood pressure, (3) screening for depression and follow-up plan, (4) follow-up after hospitalization for mental illness, (5) plan all-cause readmissions, (6) adult body mass index assessment, (7) prevention quality indicator (PQI) 92: chronic conditions composite, (8) admission to an institution from the community, (9) ambulatory care: emergency department visits, and (10) inpatient utilization.[158]

7. Meaningful Measures Framework

Launched in 2017, CMS's comprehensive Meaningful Measures Framework initiative identifies high priority areas for quality measurement and improvement to improve outcomes for patients, their families, and providers while also reducing burden on clinicians and providers. The Meaningful Measure areas serve as the connectors between CMS strategic goals and individual measures or initiatives and demonstrate how high quality outcomes for beneficiaries are being achieved. The Meaningful Measures Framework helps programs to identify and select individual

[157] https://www.medicaid.gov/medicaid/ltss/health-homes/index.html

[158] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/2019-health-home-core-set.pdf

measures to improve measure alignment and identify high priority areas where there may be gaps in measurement. CMS engages stakeholders to provide input to inform the framework, implement the framework, and evaluate current measure sets to inform measure development.

This initiative is structured around four CMS strategic goals: (1) improve CMS customer experience, (2) provide state flexibility and local leadership, (3) support innovative approaches, and (4) empower patients and doctors. The four strategic goals connect to six-cross cutting criteria: (1) eliminating disparities, (2) tracking to measurable outcomes and impact, (3) safeguarding public health, (4) achieving cost savings, (5) improving access for rural communities, and (6) reducing burden.

CMS has identified six domains around which Meaningful Measures are organized: (1) promote effective communication and coordination of care, (2) promote effective prevention and treatment of chronic disease, (3) work with communities to promote best practices of healthy living, (4) make care affordable, (5) make care safer by reducing harm caused in the delivery of care, and (6) strengthen person and family engagement as partners in their care.[159]

8. Data Interoperability

CMS has launched several initiatives to improve the experience of care among Medicaid and CHIP beneficiaries to promote patient empowerment. Interoperability, a pillar of these initiatives, centers on seamless data sharing between health systems and with patients.

- **Interoperability and Patients Over Paperwork.** To further our long-term goal that health care data be able to follow the patient, CMS is working toward specifying what types of information – ideally in electronic format – must be shared by hospitals with a patient's receiving facility or post-acute care provider. In June 2018, CMS launched a database called the Data Element Library (DEL) to support interoperability.[160] Using this free, centralized resource, the public can view the specific types of data that CMS requires post-acute care facilities (such as nursing homes and rehabilitation hospitals) to collect as part of the health assessment of their patients. The DEL also includes the health information technology (HIT) standards that support the collection of health information, which are the nationally agreed upon methods for connecting electronic health systems together.
- **Promoting Interoperability Program.** In April 2018, CMS renamed the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability Programs to signal a new focus on interoperability and improving patient access to health information.[161] CMS is also taking steps against information blocking, by requiring hospitals and clinicians under some CMS programs to show they have supported health information exchange and the prevention of information blocking.[162]

[159] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html

[160] https://www.cms.gov/newsroom/press-releases/cms-launches-data-element-library-supporting-interoperability

[161] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

[162] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

III. REPORTING OF QUALITY MEASURES

A. Core Sets of Child and Adult Health Care Quality Measures

The Medicaid and CHIP Child and Adult Core Sets of health care quality measures (Core Sets) support federal and state efforts to collect, report, and use a standardized set of measures to drive improvement in the quality of care provided to Medicaid and CHIP beneficiaries. The Child Core Set was established under Section 1139A of the Social Security Act (amended by Title IV of CHIPRA) and states began voluntarily reporting the measures in 2011. The Adult Core Set was established under Section 1139B of the Social Security Act (amended by Section 2701 of the ACA), and states began voluntarily reporting the measures in 2013. The Child and Adult Core Sets include measures organized around six domains of care: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Dental and Oral Health Services (Child Core Set only), and (6) Experience of Care.

Since its inception, reporting for the Child and Adult Core Sets has been voluntary for states. However, as part of Section 50102 of the Advancing Chronic Care, Extenders and Social Services (ACCESS) Act of 2018, mandatory state reporting of the Child Core Set measures will take effect in 2024.[163] Additionally, the SUPPORT Act for Patients and Consumers will require mandatory reporting of Behavioral Health Care measures in the Adult Core Set beginning in 2024.[164] CMS has been working closely with states to improve the quality and completeness of Core Set measure reporting in preparation for mandatory reporting in 2024. CMS annually releases information on state progress on reporting the Child and Adult Core Set measures and assesses state-specific performance for measures that were reported by at least 25 states and that met CMS standards for data quality.[165]

The Secretary of HHS is required to review and update the Child and Adult Core Sets annually.[166] CMS works with a multi-stakeholder group comprised of state representatives, health care providers, and quality measurement experts to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. Changes to the 2017–2019 Child and Adult Core Sets are outlined below and shown in Figures 1 and 2.

CMS, in partnership with the Agency for Healthcare Policy and Research (AHRQ), established the PQMP to further improve and strengthen the Child Core Set through the development, dissemination, and implementation of pediatric-specific quality measures. In October 2016, the PQMP embarked on a new phase of work seeking to improve and refine the quality measures

[163] https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.xml

[164]The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act): https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf

[165] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set/index.html; https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set/index.html

[166] https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm and https://www.ssa.gov/OP_Home/ssact/title11/1139B.htm

that were developed during the initial phase of the program. In accordance with Title III, Sec. 304(b) of MACRA, the continued PQMP efforts build knowledge and evidence to support performance monitoring and QI for children in Medicaid and CHIP by:

- Increasing the number of new measures being implemented and reported at multiple levels (state, health plan, and provider) in key gap areas;
- Informing efforts to streamline data collection and reporting processes; and
- Supporting States to drive improvement in health care quality using the Child Core Measures and the PQMP measures.

Changes to the Child Core Set

Figure 1 identifies the measures in the Child Core Set, noting which measures were added to or retired from the Child Core Set during the 2017–2019 annual updates. The 2016 Child Core Set is shown for comparison.

- 2017
  - Two measures were added to the 2017 Child Core Set: (1) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure was added to promote the use of nonpharmacologic, evidence-informed approaches for the treatment of mental and behavioral health problems among children in Medicaid and CHIP who are on psychotropic medications, and (2) Contraceptive Care – Postpartum Women Ages 15–20 measure was added to the 2017 Child Core Set to assess the provision of a most or moderately effective method of contraception within 3 and 60 days of delivery.
  - No measures were retired from the 2017 Child Core Set. However, the Human Papillomavirus (HPV) Vaccine standalone measure was incorporated as a new rate under the Immunizations for Adolescents measure due to a change made by the measure steward.
- 2018
  - Three measures were added to the 2018 Child Core Set: (1) Asthma Medication Ratio: Ages 5–18 measure replaced the Medication Management for People with Asthma measure, included in the 2013–2017 Child Core Sets; (2) Contraceptive Care – All Women Ages 15–20 measure was added to assess access to contraceptive care for those in need of services; and (3) Screening for Depression and Follow-Up Plan: Ages 12–17 measure was added to align with the Adult Core Set and replaced the Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure.
  - Four measures were retired from the 2018 Child Core Set: (1) Behavioral Health Risk Assessment (for Pregnant Women) measure, which was retired due to implementation and data collection challenges; (2) Frequency of Ongoing Prenatal Care measure, because it did not assess the content of the prenatal care visit; (3) Medication Management for People with Asthma measure, which was replaced with another asthma measure; and (4) Child and Adolescent Major Depressive Disorder: Suicide Risk

Assessment measure, which was replaced with a measure focused on depression screening and follow-up care.

- 2019
  - No measures were added to or retired from the 2019 Child Core Set.

Changes to the Adult Core Set

Figure 2 identifies the measures in the Adult Core Set, noting which measures were added to or retired from the Adult Core Set during the 2017–2019 annual updates. The 2016 Adult Core Set is shown for comparison.

- 2017
  - Three measures were added to the 2017 Adult Core Set: (1) Contraceptive Care – Postpartum Women Ages 21–44 measure was added to assess the provision of a most or moderately effective method of contraception within 3 and 60 days of delivery; (2) Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence measure was added to address priority areas of access and follow-up of care for adults with mental health or substance use disorders; and (3) Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was added to address chronic disease management for people with serious mental illness and assess integration of physical and behavioral health care services.
  - One measure, Timely Transmission of Transition Record, was retired from the 2017 Adult Core Set due to implementation and data collection challenges.
- 2018
  - Three measures were added to the 2018 Adult Core Set: (1) Asthma Medication Ratio: Ages 19–64, was added to align with the 2018 Child Core Set; (2) Contraceptive Care – All Women Ages 21–44 was added to assess access to contraceptive care for those in need of services; and (3) Concurrent Use of Opioids and Benzodiazepines was added to address early opioid use and polypharmacy.
  - No measures were retired from the 2018 Adult Core Set.
- 2019
  - No measures were added to the 2019 Adult Core Set.
  - The PC-03: Antenatal Steroids measure was retired from the 2019 Adult Core Set due to implementation and data collection challenges. Additionally, the Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence measure was separated into two distinct measures to align with the measure steward: (1) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and (2) Follow-Up After Emergency Department Visit for Mental Illness.

B. Supporting Voluntary Reporting of the Core Set Measures

CMS's goals for the reporting of quality measures in the Child and Adult Core Sets are to:

- Maintain or increase the number of states reporting each measure
- Maintain or increase the number of measures reported by each state
- Improve the completeness of data reported by states by encouraging them to report Child Core Set measures for both their Medicaid and CHIP populations and Adult Core Set measures for Medicaid enrollees age 65 and older and to report across all health care delivery systems (i.e., fee-for-service (FFS), managed care, etc.)
- Improve the accuracy, consistency, and comparability of state data through an enhanced data quality review and outreach effort
- Where possible, streamline data collection and reporting processes to reduce the burden on states
- Support states' use of Core Set data to drive health care quality improvement

CMS conducts a variety of activities to support states in their voluntary reporting of the Child and Adult Core Set measures, to improve quality measurement, and to help states better access and use the data that they have available for reporting the Core Sets. An essential vehicle for these efforts is the Technical Assistance and Analytic Support (TA/AS) for the Medicaid and CHIP Quality Measurement and Improvement Program, through which CMS supports state efforts to collect, report, and use the Child and Adult Core Set measures for quality improvement. For example:

- CMS produces resources, including issue briefs, fact sheets, sample SAS code, and toolkits, to address common reporting challenges. Recent activities have included updating the annual Technical Specifications and Resource Manuals to address frequently asked questions and data quality issues, maintaining data quality checklists to help states assess the accuracy and completeness of their data, and developing technical assistance briefs and sample SAS code to help states calculate measures consistently and accurately.
- CMS hosts state-attended webinars that cover critical components of Core Set reporting and provide targeted assistance on key topics or new measures with the goal of driving improvement in quality of care in Medicaid and CHIP. For example, in June 2018, CMS hosted a webinar to guide states through the calculation of Substance Use Disorder measures in the Adult Core Set. In May 2019, CMS hosted a webinar to review substantial changes to the Child, Adult, and Section 1945 Health Homes Core Sets for FFY 2019. In July 2019, CMS hosted a webinar on stratifying Core Set measures to drive improvement in quality of care in Medicaid and CHIP.
- CMS provides one-on-one technical assistance to states experiencing unique challenges with data collection, measure calculation, and reporting, and conducts targeted outreach at the beginning of each reporting year to help increase the number of states reporting high-priority measures.
- CMS operates a TA Mailbox to respond to states' technical questions about calculating and reporting measures using Core Set specifications, and to provide additional resources for reporting. Since January 2017, the TA/AS Team has responded to more than 700 inquiries, many of which pertain to measure calculation, data sources, and measurement periods.

Lastly, the web-based MACPro reporting system remains a key vehicle for states to collect and report performance on the Child and Adult Core Set measures. In the interest of facilitating state reporting, CMS continues to improve the user-friendliness of the MACPro system, and holds detailed webinars on system functionality each year. CMS also works one-on-one with state MACPro users to address their reporting questions and to troubleshoot technical challenges.

C. State Reporting of the Child and Adult Core Set Measures for FFY 2016-2018

With nine years of voluntary state reporting on the Child Core Set and six years on the Adult Core Set, the number of states reporting at least one measure as well as the number of states reporting each measure, has increased substantially. CMS annually reports information on state performance on the Child and Adult Core Set measures that were reported by at least 25 states and that met CMS standards for data quality. Notably, for FFY 2018, which generally covers care delivered in calendar year 2017, CMS publicly reported performance on 23 of the 26 Child Core Set measures and 23 of the 33 Adult Core Set measures, including 8 measures that are being publicly reported for the first time. CMS's continued work with states has resulted in an increase in publicly reported measures for FFY 2018, an increase in the number of states reporting, and improvements in the quality of data reported by states.

1. Status of Child Core Set Reporting

The number of states reporting Child Core Set measures has increased substantially since the release of the Child Core Set in 2010. All states and the District of Columbia[167] voluntarily reported at least one Child Core Set measure for FFYs 2017 and 2018, compared to 49 states plus the District of Columbia for FFY 2016. The median number of measures reported by states was 18 for FFY 2018, which is consistent with the median number of measures reported for FFYs 2016 and 2017 (Figure 3). The number of states reporting at least half of the Child Core Set measures each year (13 measures) stayed consistent from FFY 2016 to FFY 2017 (45 states) and decreased slightly to 43 states for FFY 2018. In addition, 26 states reported more Child Core Set measures for FFY 2018 than for FFY 2016.

CMS has also encouraged states to report data for both their Medicaid and CHIP populations. For FFY 2018, 46 states included both Medicaid and CHIP beneficiaries in reporting on at least one measure, a decrease as compared to 47 states for FFY 2017, and an increase from 45 states for FFY 2016.

For FFY 2018, CMS is publicly reporting state performance on 23 of the 26 Child Core Set measures, up from 20 of 27 measures for FFY 2017 and 21 of 26 measures for FFY 2016. CMS publicly reported six Child Core Set measures for the first time between FFY 2016 and FFY 2018:

1. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) (FFY 2016)
2. Developmental Screening in the First Three Years of Life (DEV-CH) (FFY 2016)

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

3. Asthma Medication Ratio: Ages 5–18 (AMR-CH) (FFY 2018)
4. Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH) (FFY 2018)
5. Contraceptive Care – All Women Ages 15–20 (CCW-CH) (FFY 2018)
6. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) (FFY 2018)

Public reporting of the AMR-CH and CCW-CH measures for FFY 2018 are notable given that they are new measures for the FFY 2018 reporting cycle. The contraceptive care measures are a focus of the MIHI, where CMS supports states in collecting and reporting these measures to assess outcomes and drive improvement. To facilitate increased and high quality reporting, these contraceptive care measures were developed and tested through MIHI grants funded by CMS.

The most frequently reported Child Core Set measures for FFY 2016 to FFY 2018 were relatively consistent over time. In FFYs 2016 and 2017, these measures were Receipt of Well-Care Visits; Access to Primary Care Practitioners; Chlamydia Screening in Women Ages 16 to 20 (FFY 2016-2017); Immunizations for Children; and Adolescent Immunization. In FFY 2018, the most frequently reported Child Core Set measures were Emergency Department Use; Use of Preventive Dental Services; and Follow-up Care After Hospitalization for Mental Illness. (See Table 2 and Figure 4).

2. Status of Adult Core Set Reporting

In FFYs 2017 and 2018, 45 states voluntarily reported at least one measure for the Adult Core Set, an increase from 41 states in FFY 2016. The median number of Adult Core Set measures reported by states was 20, an increase from 17 measures in both FFYs 2016 and 2017. The number of states reporting at least half of the Adult Core Set measures increased from 31 states in FFY 2016 (14 measures) to 34 states in FFY 2017 (15 measures), and then decreased to 32 states in FFY 2018 (Figure 5). In addition, 37 states reported more Adult Core Set measures in FFY 2018 than in FFY 2016.

CMS publicly reported state performance on 23 of the 33 Adult Core Set measures in FFY 2018, up from 16 of 28 measures in FFY 2016 and 19 of 30 measures in FFY 2017. CMS publicly reported the following 11 Adult Core Set measures for the first time between FFY 2016 and FFY 2018:[168]

1. Controlling High Blood Pressure (CBP-AD) (FFY 2016)
2. Prevention Quality Indicator (PQI) 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) (FFY 2016)
3. PQI 08: Heart Failure Admission Rate (PQI08-AD) (FFY 2016)

[168] In addition, due to measure specification changes for the Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence measure for FFY 2018, performance data for this measure are being reported for the first time by diagnosis cohort, including alcohol abuse or dependence, opioid abuse or dependence, other drug misuse or dependence, and total AOD abuse or dependence.

4. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD) (FFY 2016)
5. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (HPC-AD) (FFY 2017)
6. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) (FFY 2017)
7. PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) (FFY 2017)
8. Asthma Medication Ratio: Ages 19–64 (AMR-AD) (FFY 2018)
9. Contraceptive Care – Postpartum Women Ages 21–44 (CCW-AD) (FFY 2018)
10. Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA/FUM-AD) (FFY 2018)
11. Plan All-Cause Readmissions: Ages 18–64 (PCR-AD) (FFY 2018)

Public reporting of the diabetes screening and adult asthma measures is noteworthy because they were new measures for FFY 2016 and FFY 2018 reporting, respectively. Additionally, the contraceptive care measure was developed and tested through the MIHI grants funded by CMS.

The most frequently reported measures for FFY 2016 to FFY 2018 were relatively consistent over time and include measures that focus on access to primary care and preventive care (breast cancer screening, cervical cancer screening, and chlamydia screening in women ages 21 to 24), diabetes management, postpartum care visits, and follow-up after hospitalization for mental illness (Table 4 and Figure 6).

D. Core Set Measures and the Medicaid and CHIP (MAC) Scorecard

The MAC Scorecard[169] was launched in 2018 to increase public transparency and accountability about the programs' administration and outcomes. The Scorecard displays Medicaid and CHIP quality measures with federally reported measures across three areas: State Health System Performance, State Administrative Accountability, and Federal Administrative Accountability.

A subset of the Child and Adult Core Set measures make up the majority of the State Health System Performance. In 2018, 12 of 13 measures were Core Set Measures. In the July 2019 version of the MAC scorecard, 17 of 21 measures were from the Core Sets. CMS updated the MAC scorecard on November 7, 2019, adding a number of additional measures, including three additional measures from the Child Core Set and two additional measures from the Adult Core Set.[170]

[169] https://www.medicaid.gov/state-overviews/scorecard/index.html

[170] https://www.cms.gov/newsroom/fact-sheets/2019-medicaid-and-chip-mac-scorecard

E. Public Reporting and Assessing Performance Over Time

CMS also analyzed trends in performance over a three-year time period. Additional criteria are applied to identify measures that are eligible for assessing trends in performance over time. For the FFY 2016–2018 time period, the analysis includes measures that meet the following criteria:

- Measure was publicly reported for all three years (FFY 2016, FFY 2017, and FFY 2018)
- Measure was reported by a set of at least 20 states that used Core Set specifications in all three years
- Measure specifications were comparable for all three years (no specification changes occurred during the three-year period that would make results incomparable across years).

Based on these criteria, there are 15 Child Core Set and 11 Adult Core Set measures that are eligible for trending during this period. Due to specification changes implemented by the measure steward, performance rates cannot be trended for six Core Set measures that were publicly reported from FFY 2016 to FFY 2018. Measures not trended include:

Child Core Set

1. Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)
2. Immunizations for Adolescents (IMA-CH): Human Papillomavirus (HPV) Vaccine Rate

Adult Core Set

3. Annual Monitoring for Patients on Persistent Medications (MPM-AD)
4. Breast Cancer Screening Ages 50 to 74 (BCS-AD)
5. Follow-Up After Hospitalization for Mental Illness: Age 21 and Older (FUH-AD)
6. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Age 18 and Older (IET-AD)

The following sections assess performance over time (FFY 2016 to FFY 2018) for the measures that could be trended, by the six Core Set domains. This section focuses on statistically significant changes in performance over the three-year period.

1. Primary Care Access and Preventive Care

Medicaid and CHIP provide access to well-child visits and other preventive health care services, including immunizations, screenings, and counseling to support healthy living. The EPSDT benefit is key to ensuring that children and adolescents enrolled in Medicaid receive appropriate preventive, dental, mental health, developmental, and specialty services. Access to regular primary care services can prevent infectious disease, chronic disease, and other health

conditions; help people live longer, healthier lives; and improve the overall health of the population.[171]

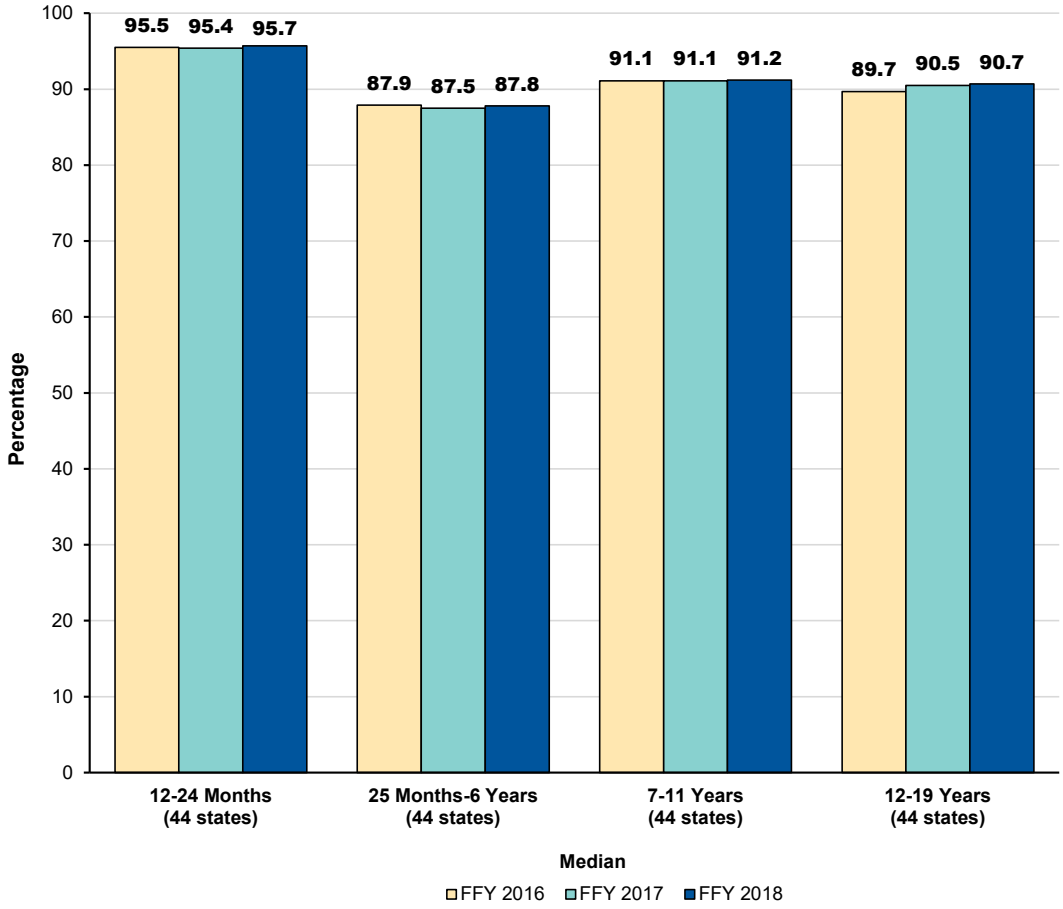
Twelve measures in the primary care access and preventive care domain (nine Child and three Adult) were available for analysis from FFY 2016 to FFY 2018 (Tables 5 and 6):

1. Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)
2. Well-Child Visits in the First 15 Months of Life (W15-CH)
3. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH)
4. Adolescent Well-Care Visits (AWC-CH)
5. Childhood Immunization Status (CIS-CH)
6. Immunizations for Adolescents (IMA-CH)
7. Developmental Screening in the First Three Years of Life (DEV-CH)
8. Chlamydia Screening in Women Ages 16–20 (CHL-CH)
9. Body Mass Index Assessment for Children/Adolescents (WCC-CH)
10. Cervical Cancer Screening (CCS-AD)
11. Chlamydia Screening in Women Ages 21–24 (CHL-AD)
12. Adult Body Mass Index Assessment (ABA-AD)

- **Primary care visits** offer the opportunity for routine care, such as determining whether children are up to date with immunizations, measuring height and weight, gathering vital signs, offering age-appropriate counseling, and generally assessing a child's wellbeing. States had consistently high performance rates on the CAP-CH measure across all three years. This measure identifies the percentage of children and adolescents ages 1 to 6 who had a visit with a primary care provider in the last year and children ages 7 to 19 who had a visit in the past two years. The following chart shows the trends in performance for the CAP-CH measure from FFY 2016 to FFY 2018 by age group.

[171] More information about prevention-related coverage policy, prevention provisions in the Affordable Care Act that affect Medicaid and CHIP, and opportunities for technical assistance is available at: https://www.medicaid.gov/medicaid/benefits/prevention/index.html. Information about EPSDT benefits is available at https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

Children and Adolescents Access to Primary Care Practitioners

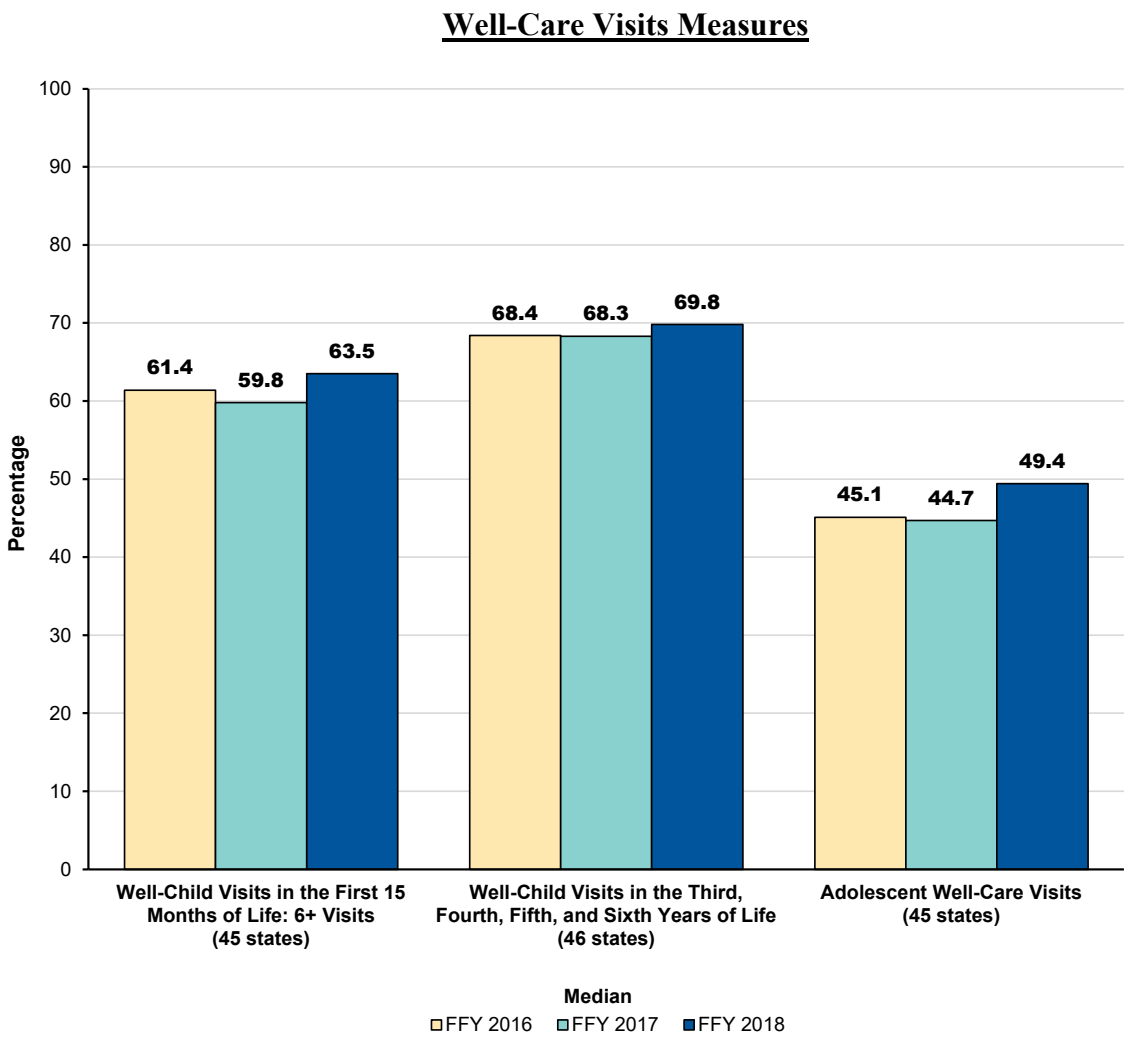


Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

- **Well-care visits** include a health history, physical examination, immunizations, screening, developmental assessment, oral health risk assessment, and referral for specialized care if necessary. In addition, well-care visits promote healthy behaviors, prevent risky ones, and detect conditions that can interfere with a teen's physical, social, and emotional development.[172] The rate of the AWC-CH measure increased significantly, by more than 4 percentage points, from a median of 45.1 percent for FFY 2016 to 49.4 for FFY 2018 among the 45 states reporting the measure for adolescents for all three years. The rates of children under 15 months and children ages 3 to 6 who received recommended well-care visits also increased significantly over the three years. Among the 45 states reporting the W15-CH measure all three years, the rate increased significantly from 61.4 percent for FFY 2016 to 63.5 percent for FFY 2018. Among the 46 states reporting the W34-CH measure all three years, the rate increased significantly from 68.4 percent for FFY 2016 to 69.8 percent for FFY 2018.

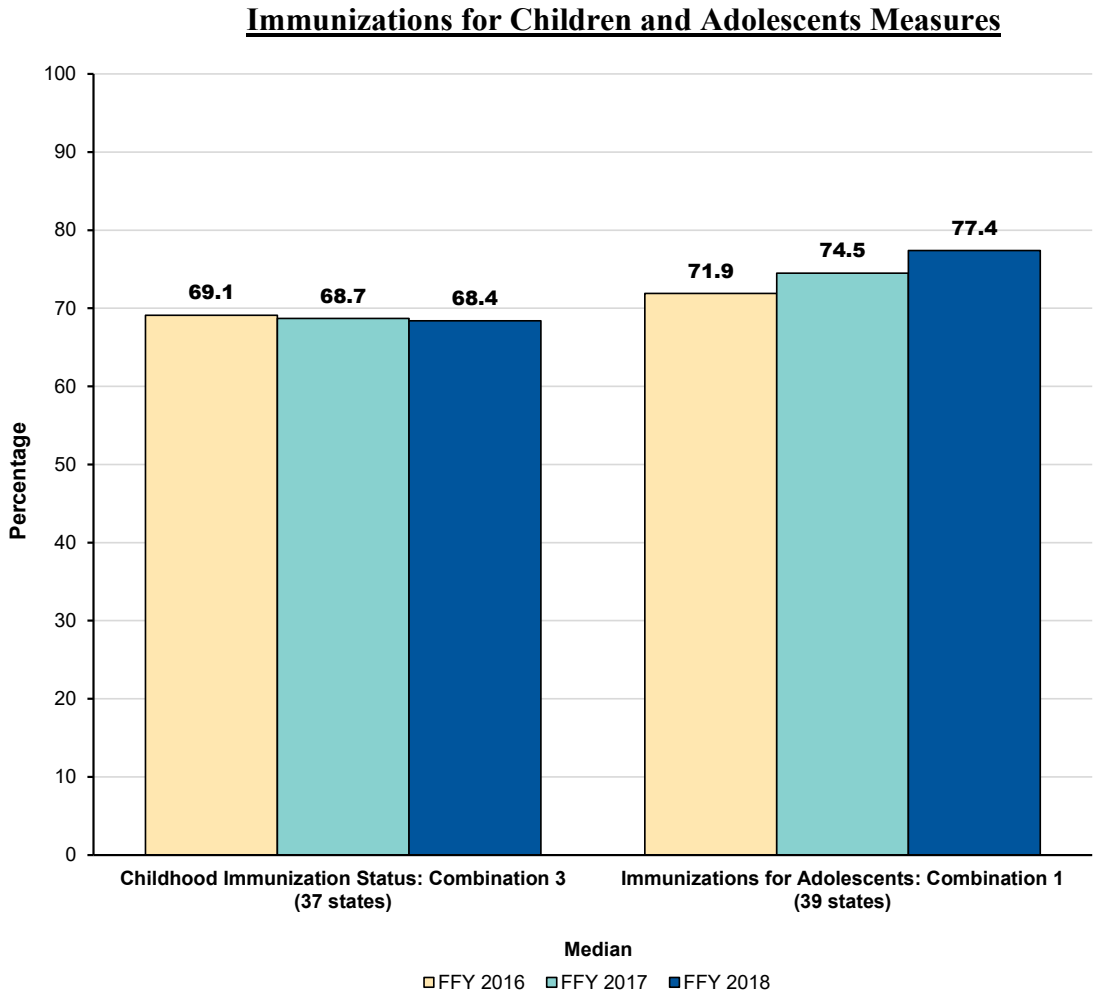
[172] The American Academy of Pediatrics and Bright Futures recommend nine well-child visits in the first 15 months of life and annual well-child visits for children ages 3 and older.



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

- **Immunizations for children and adolescents** can be used to indicate the continuity and clinical quality of primary care. The median rate of adolescents who were up to date on their Combination 1 (Meningococcal Conjugate and Tdap Vaccines) immunization (IMA-CH) increased significantly by more than 5 percentage points, from 71.9 percent for FFY 2016 to 77.4 percent for FFY 2018 among the 39 states reporting the measure. Median performance did not change significantly during this period for the CIS-CH (Combination 3) measure, which identifies the percentage of children who received specific combinations of vaccines by age 2.



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

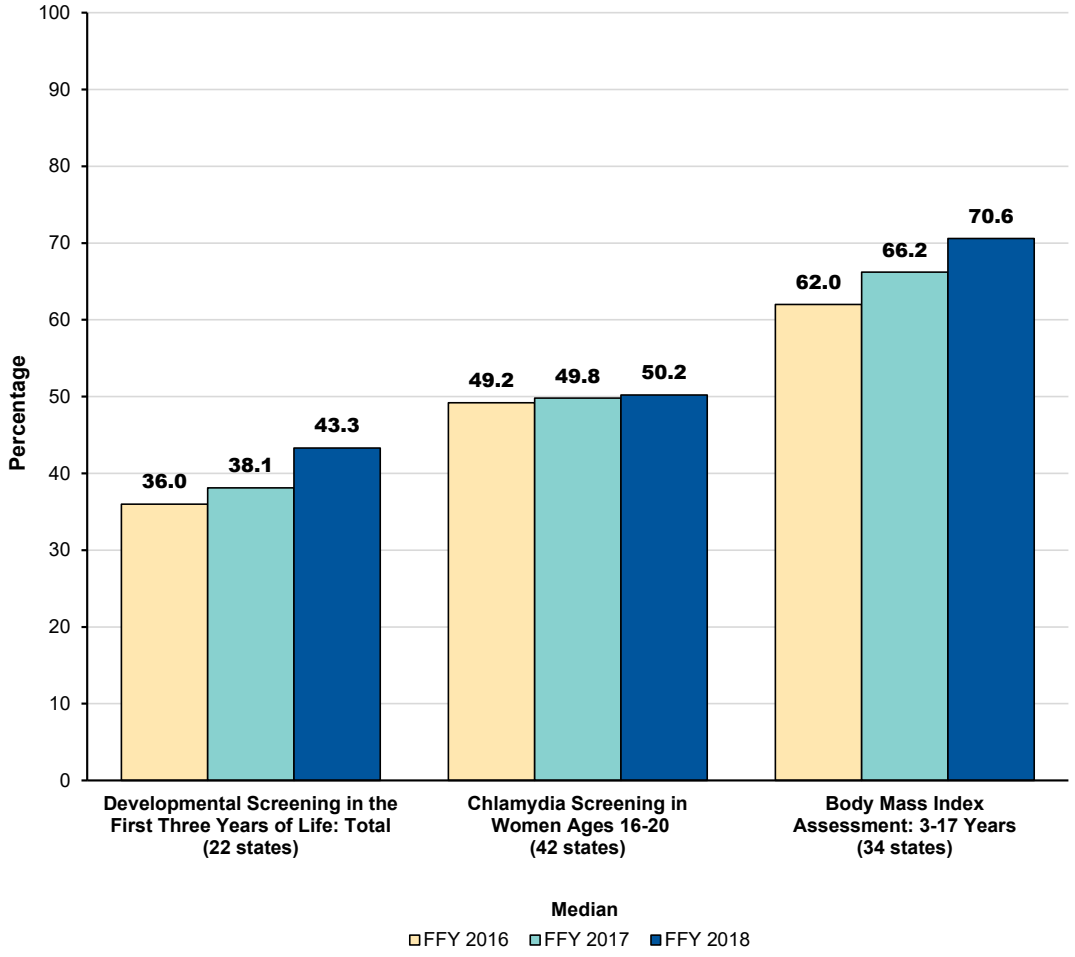
- **Developmental screening** can improve a child's health, social, and academic outcomes. Among the 22 states that reported the DEV-CH measure for the past three years, the median rate increased significantly, by more than 7 percentage points, from a median of 36.0 percent for FFY 2016 to 43.3 percent for FFY 2018.
- **Chlamydia screening** plays an essential role in supporting women's health and is recommended for young adult women who are sexually active. The rate of chlamydia screening among sexually active women between the ages of 16 and 20 (CHL-CH) increased from a median of 49.2 percent for FFY 2016 to 50.2 percent for FFY 2018 among the 42 states reporting the measure for all three years. The median rate for women ages 21 to 24 (CHL-AD) did not change significantly over the three-year period.
- **Monitoring of body mass index (BMI)** helps providers identify children and adults who have overweight or obesity and are at increased risk for related health complications. Among the 34 states that reported the WCC-CH measure for the past three years, the median

rate of children with a BMI percentile documented in the medical record increased significantly, by more than 8 percentage points, from 62.0 percent for FFY 2016 to 70.6 percent for FFY 2018. For the ABA-AD measure – the median state performance increased significantly, by more than 3 percentage points, from 79.9 percent for FFY 2016 to 83.0 percent for FFY 2018 among the 29 states that reported the measure all three years. These increases may be due in part to the use of medical chart review to more accurately capture the information for this measure.

- **Cervical cancer screening** is an indicator of the quality of preventive care services provided to women enrolled in Medicaid. The median rate for the CCS-AD measure did not change significantly during this period.

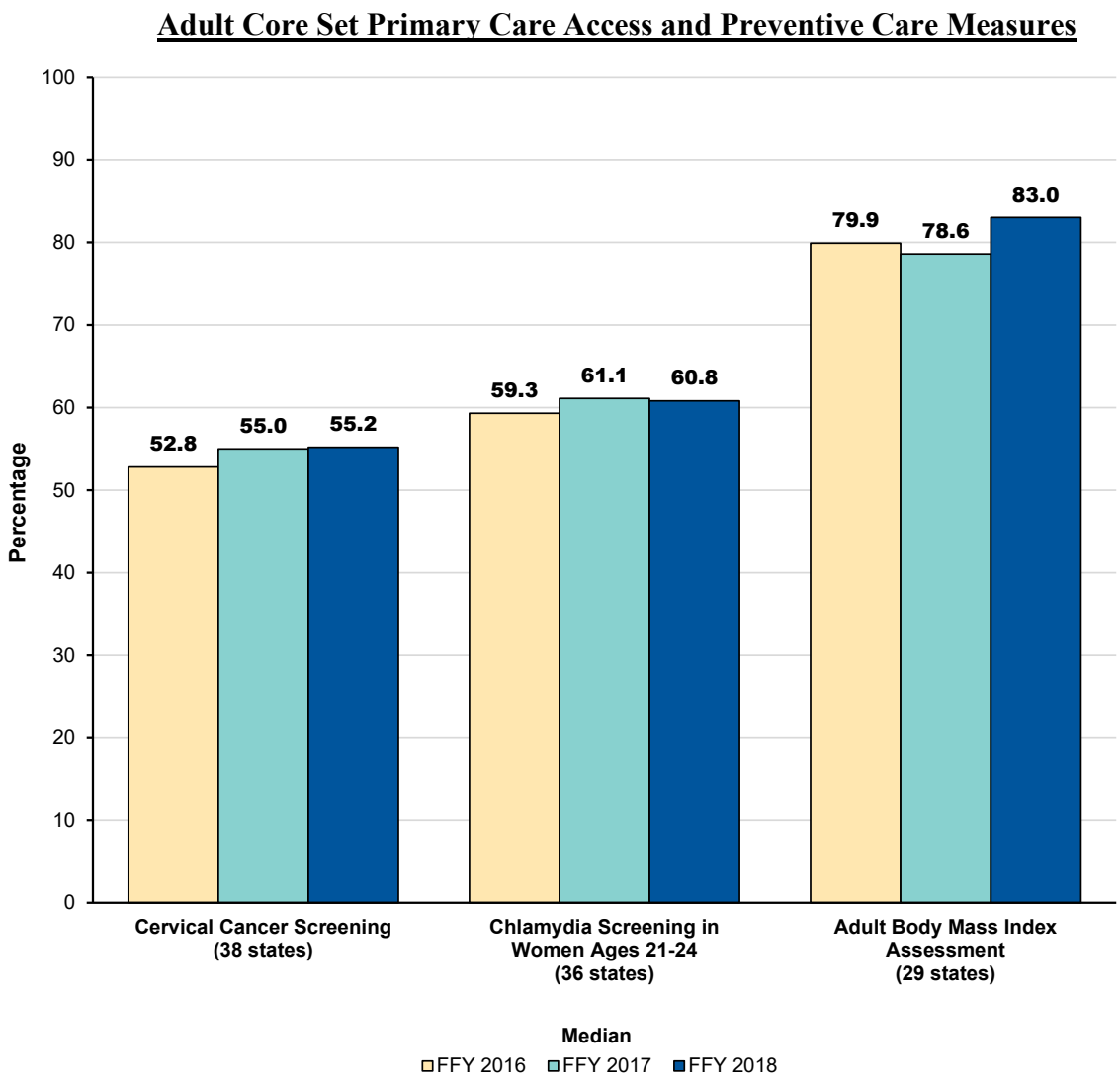
The following charts show the trends in performance for the remaining Child and Adult Core Set measures included in the Primary Care Access and Preventive Care domain.

Other Child Core Set Primary Care Access and Preventive Care Measures



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported each measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported each measure using Adult Core Set specifications for all three years. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

2. Maternal and Perinatal Health[173]

As the principal source of payment for 42 percent of all live births in the United States in 2018,[174] including 46.6 to 62 percent of live births in 13 states,[175] Medicaid has an important role to play in improving perinatal health outcomes. The health of a child is affected by a mother's health and the care she receives during pregnancy. When a woman accesses the health care system for

[173] More information about CMS's efforts to improve maternal and infant health care quality is available at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/index.html.

[174] https://www.cdc.gov/nchs/nvss/births.htm

[175] National Center for Health Statistics, 2017 Natality Public Use Data available at https://wonder.cdc.gov/.

maternity care, an opportunity is presented to promote services and behaviors to optimize her health and the health of her child.

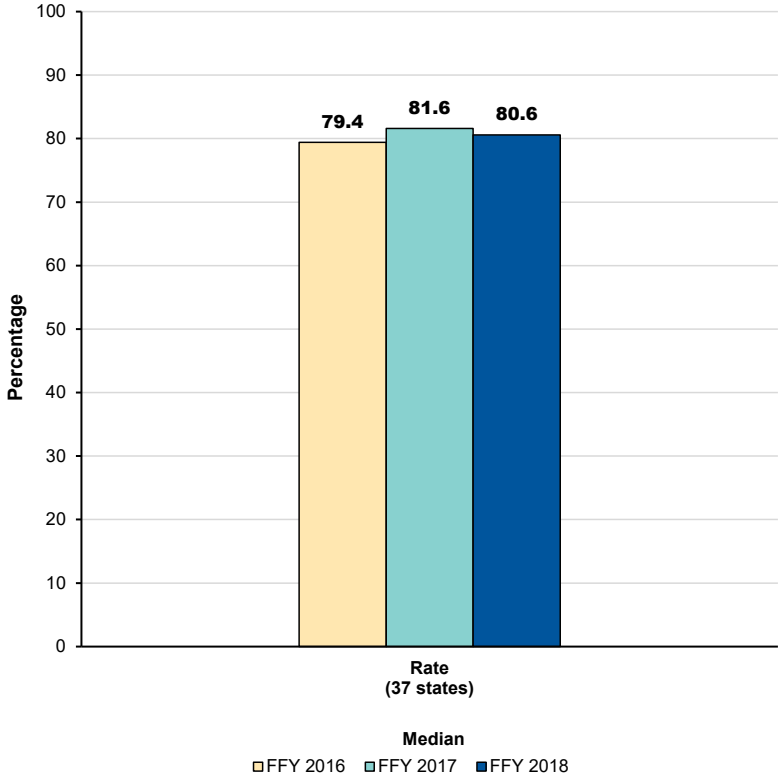
Two measures in the maternal and perinatal health domain (one Child and one Adult) were available for analysis from FFY 2016 to FFY 2018 (Tables 5 and 6):

1. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
2. Prenatal and Postpartum Care: Postpartum Care (PPC-AD)

- **Prenatal and postpartum care** can prevent pregnancy complications resulting from pre-existing health conditions, promote access to recommended care, improve birth spacing and timing, and improve the health outcomes of women and children. The Postpartum Care measure (PPC-AD) identifies the percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery. Median state performance on the PPC-AD measure increased significantly, by more than 7 percentage points, from 55.2 percent for FFY 2016 to 62.7 percent for FFY 2018 among the 31 states reporting the measure all three years. The Timeliness of Prenatal Care measure (PPC-CH) identifies the percentage of deliveries of live births during the measurement year that had a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid or CHIP. Median performance on the PPC-CH measure did not change significantly from FFY 2016 to FFY 2018.

The following charts show the trends in performance for the Prenatal and Postpartum Care measures in the Child and Adult Core Sets.

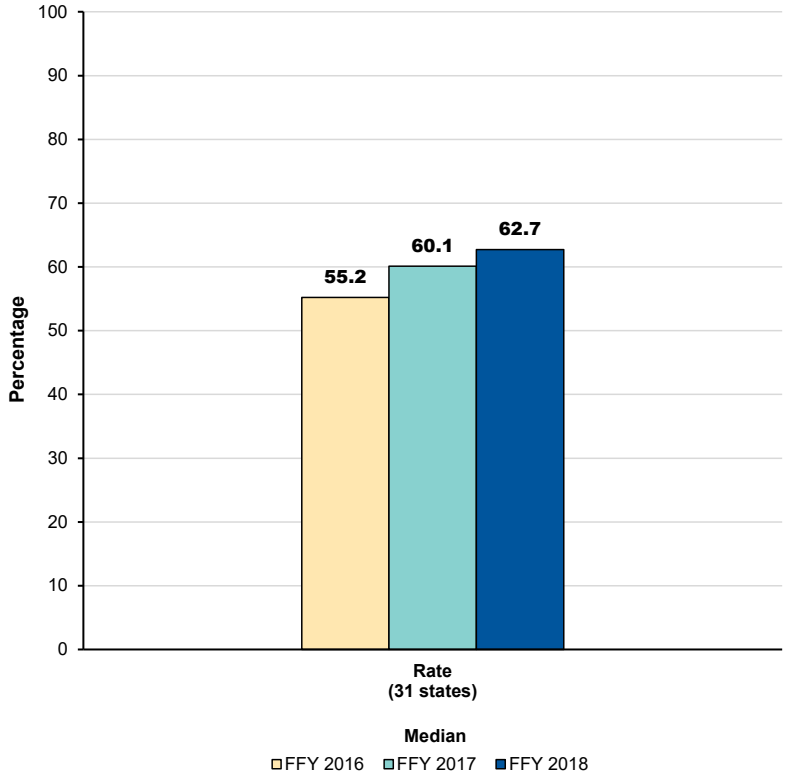
Prenatal and Postpartum Care: Timeliness of Prenatal Care Measure



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported each measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

Prenatal and Postpartum Care: Postpartum Care Measure



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported each measure using Adult Core Set specifications for all three years. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack

3. Acute and Chronic Conditions

The extent to which children and adults receive safe, timely, and effective care for acute and chronic conditions is a key indicator of the quality of care provided in Medicaid and CHIP. 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 emergency department (ED) visits.

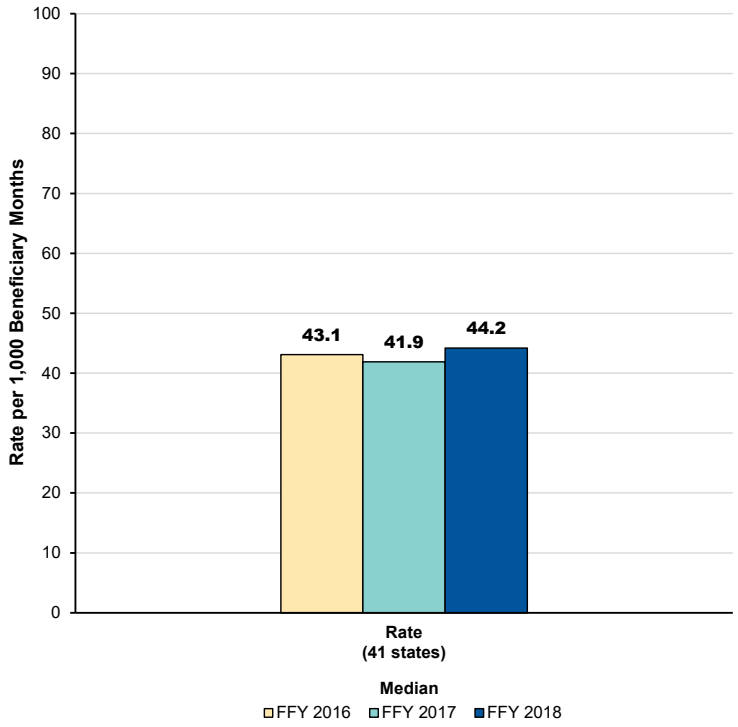
Five measures in the care of acute and chronic conditions (one Child and four Adult) were available for analysis from FFY 2016 to FFY 2018 (Tables 5 and 6):

1. Ambulatory Care: Emergency Department Visits (AMB-CH)
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)
3. PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)
4. Controlling High Blood Pressure (CBP-AD)
5. PQI 08: Heart Failure Admission Rate (PQI08-AD)

- **Emergency department visits** may indicate lack of access to more appropriate sources of medical care, such as primary care providers or specialists. Understanding the rate of

emergency department visits among children covered by Medicaid and CHIP can help states identify strategies to improve access to and utilization of appropriate sources of care. Lower rates are better on this measure. The median rate for the AMB-CH measure was consistent from FFY 2016 to FFY 2018.

Ambulatory Care: Emergency Department (ED) Visits Measure



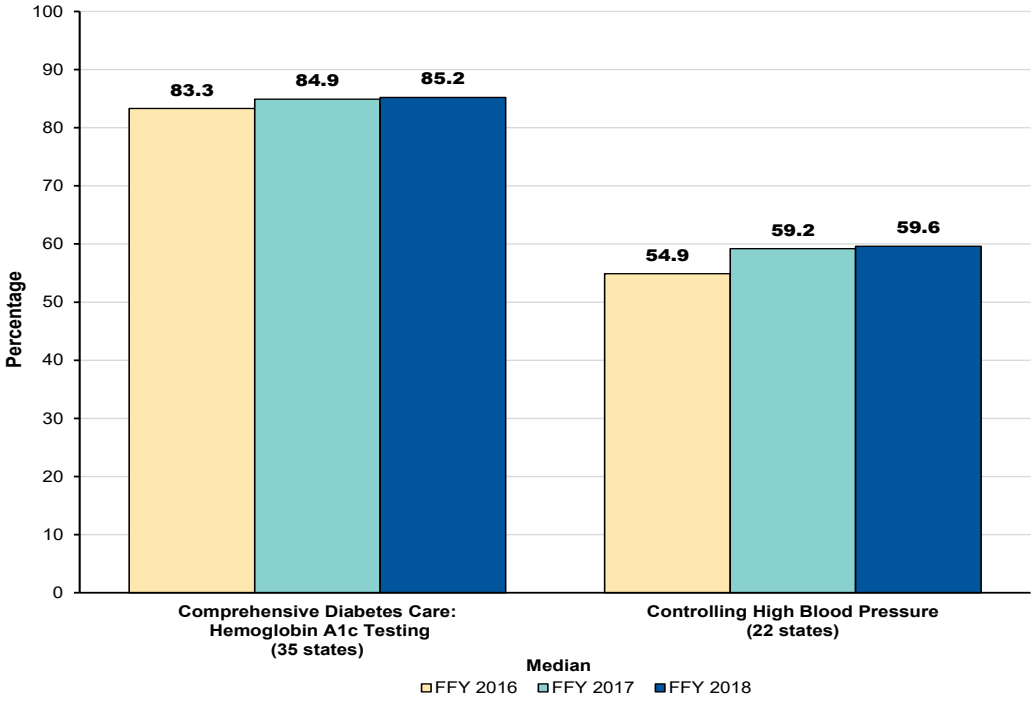
Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

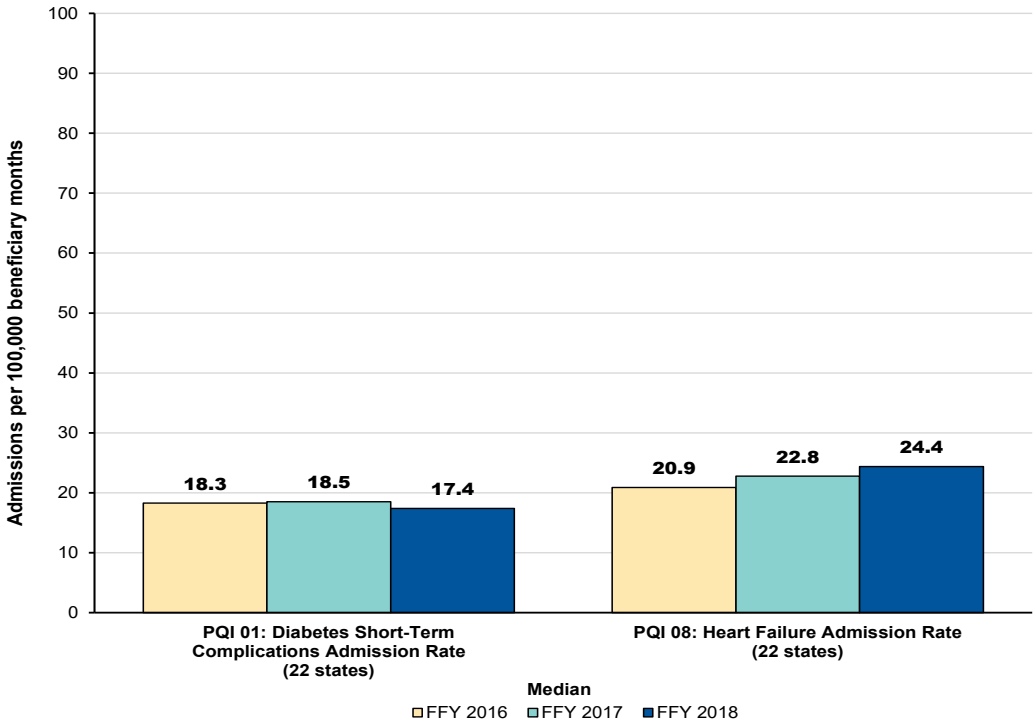
Notes: This chart includes the states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

- **Diabetes management** is essential to control blood glucose levels, reduce risks of complications, and support longer lifespan. Median state performance on the HA1C-AD and PQI 01-AD measures did not change significantly from FFY 2016 to FFY 2018.
- **Blood pressure management** is an important step in preventing heart attacks, strokes, and kidney disease, and in reducing the risk of developing other serious conditions. Median state performance on the CBP-AD measure did not change significantly from FFY 2016 to FFY 2018.
- **Inpatient hospital admissions for heart failure** can be an indicator that the condition is not being properly managed, as heart failure can be treated, controlled, and monitored in outpatient settings. The median rate for the PQI 08-AD measure increased significantly from FFY 2016 to FFY 2018, from 20.9 per 100,000 beneficiary months to 24.4 per 100,000 beneficiary months among the 22 states reporting the measure for all three years, representing a decline in performance because lower rates are better on this measure.

The trends for the remaining Child and Adult Core Set measures under the Care of Acute and Chronic Conditions domain are shown in the charts below.

Adult Core Set Care of Acute and Chronic Conditions Measures





Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: These charts include the states that reported each measure using Adult Core Set specifications for all three years. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

4. Behavioral Health

As the single largest payer for mental health services in the United States, Medicaid plays an important role in providing behavioral health care to children and adults, and monitoring the effectiveness of that care. For the purpose of this report, the term "behavioral health care" refers to treatment of mental health conditions, substance use disorders, and other behavioral conditions. Improving benefit design and service delivery for behavioral health care in Medicaid is a high priority for CMS, in collaboration with other federal agencies, states, providers, and consumers.[176]

Five measures in the behavioral health care domain (two Child and three Adult) that were publicly reported for FFY 2018 (Tables 5 and 6), were available for trending from FFY 2016 to FFY 2018:

1. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
2. Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
3. Antidepressant Medication Management (AMM-AD)
4. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
5. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

- **Concurrent use of antipsychotic medications** in children and adolescents has increased over time. Concerns related to the simultaneous use of two or more of these medications in children have grown regarding appropriate use, medication management, and potential side effects. This measure identifies the percentage of children and adolescents ages 1 to 17 who were on two or more concurrent antipsychotic medications for at least 90 consecutive days. A lower rate is better for this measure. Median state performance on the APC-CH measure did not change significantly between FFY 2016 and FFY 2018.
- **Follow-up care for children prescribed ADHD medication** is an indicator of the continuity of care for children with a chronic behavioral health condition. Clinical guidelines recommend a follow-up visit within 30 days for children who are newly prescribed ADHD medication for medication management. Among those remaining on ADHD medication, two additional visits are recommended during the 9-month continuation and maintenance phase for ongoing medication management and assessment. This measure identifies the percentage of children ages 6-12 who were newly prescribed ADHD medication and had at least three follow-up visits within a 10 month period. Median state performance on the ADD-CH measure did not change significantly between FFY 2016 and FFY 2018.
- **Effective antidepressant medication management** is an important standard of care for patients receiving treatment for depression. This measure identifies the percentage of adults age 18 and older diagnosed with major depression who were treated with antidepressant

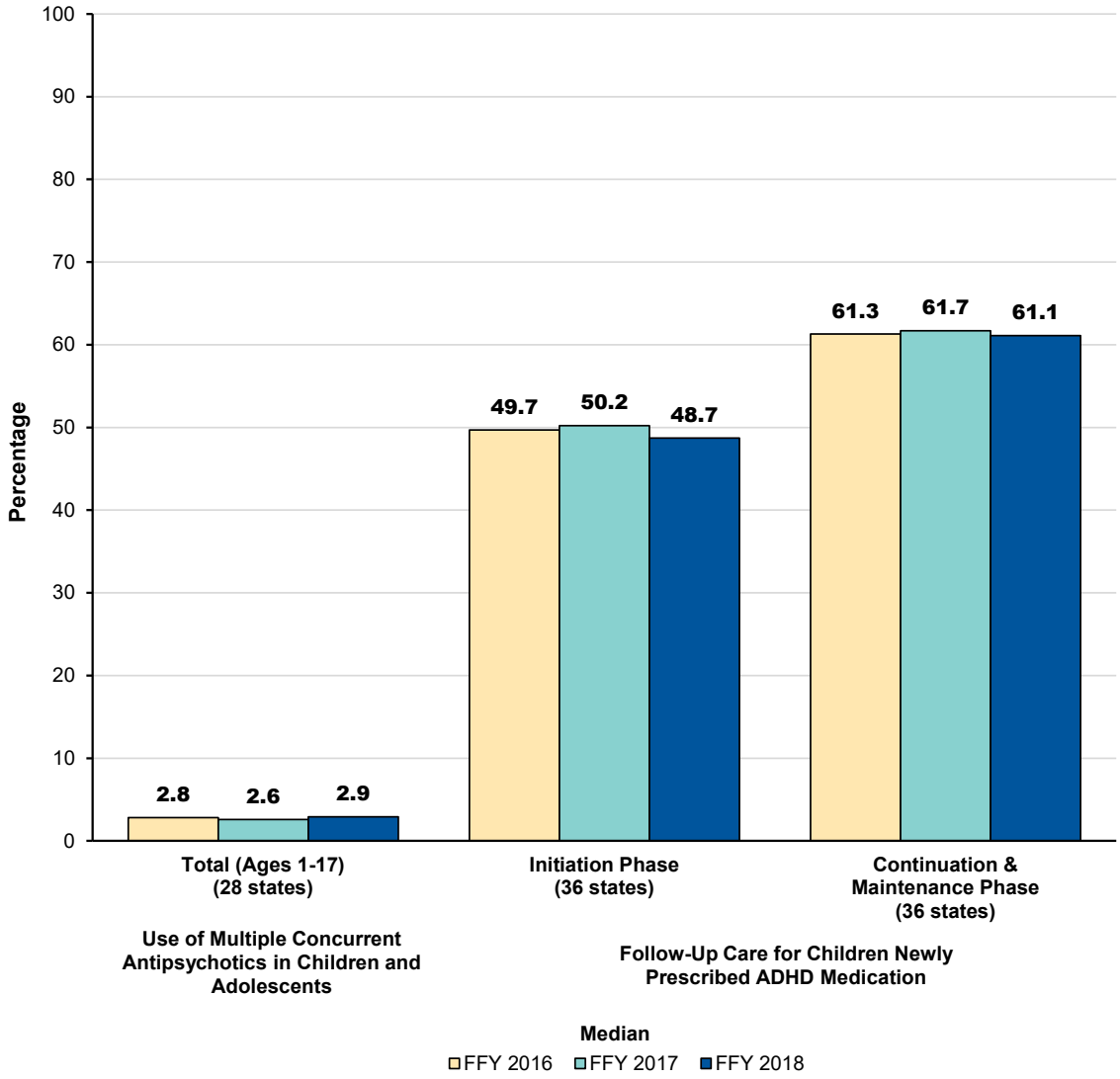
[176] https://www.medicaid.gov/medicaid/benefits/bhs/index.html

medication and remained on antidepressant medication treatment for the 12-week acute phase and 6-month continuation phase. Median state performance on the AMM-AD measure (acute and continuation phases) did not change significantly between FFY 2016 and FFY 2018.

- **Antipsychotic medication adherence** is crucial for patients with schizophrenia, as it can reduce the risk of relapse or hospitalization. This measure indicates the percentage of Medicaid beneficiaries with schizophrenia who remained on an antipsychotic medication for at least 80 percent of their treatment period. Median state performance on the SAA-AD measure did not change significantly between FFY 2016 and FFY 2018.
- **Diabetes screening for people with schizophrenia or bipolar disorder** who are using antipsychotic medications is essential, since these individuals are at a greater risk of developing diabetes. Lack of appropriate screening can lead to adverse health outcomes if diabetes is not detected and treated. This measure assesses whether Medicaid beneficiaries with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening test. Median performance on the SSD-AD measure increased significantly from FFY 2016 to FFY 2018, from 78.6 percent for FFY 2016 to 79.6 percent for FFY 2018 among the 23 states reporting the measure.

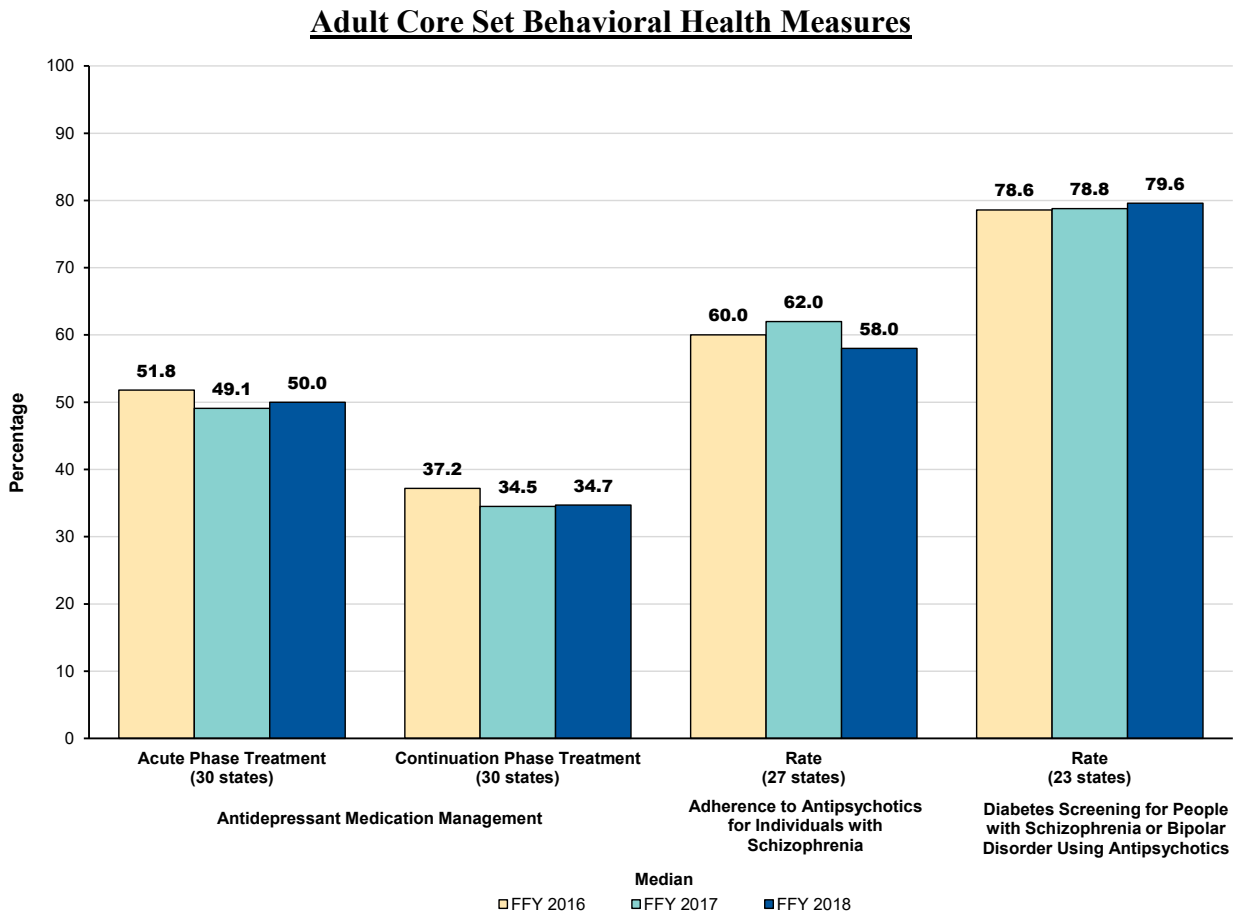
The following charts show the trends in performance for the Child and Adult Core Set measures included in the Behavioral Health domain.

Child Core Set Behavioral Health Measures



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported each measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: This chart includes the states that reported each measure using Adult Core Set specifications for all three years.

Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

5. Dental and Oral Health Services

All children enrolled in Medicaid and CHIP have coverage for dental and oral health services. Children's oral health is important to their overall health, both in childhood and later in adulthood. Improving children's access to oral health care in Medicaid and CHIP continues to be a focus of federal and state efforts.[177]

Both of the dental and oral health measures in the Child Core Set were available for trending (Table 5):

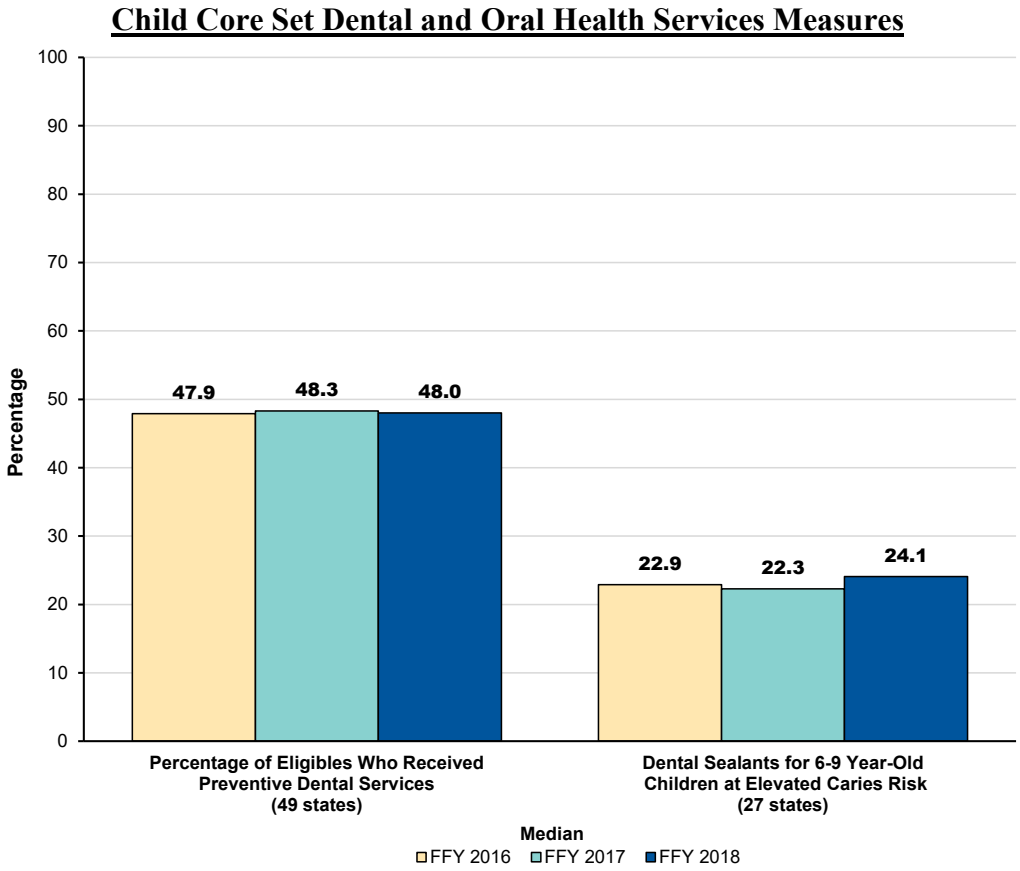
1. Percentage of Eligible Who Received Preventive Dental Services (PDENT-CH)
2. Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (SEAL-CH)

[177] More information about CMS's Oral Health Initiative is available at https://www.medicaid.gov/medicaid/benefits/dental-care/index.html.

- **Preventive dental services** promote healthy oral hygiene habits and reduce dental caries (tooth decay). Childhood caries is one of the most common chronic diseases of children, and is almost entirely preventable through a combination of good oral health habits at home (i.e., brushing with fluoride toothpaste and drinking fluorinated water), a healthy diet, and early and regular use of preventive dental services. This measure assesses the percentage of children ages 1 to 20 who received preventive dental services. Median state performance on the PDENT-CH measure did not change significantly between FFY 2016 and FFY 2018.

- **Dental sealants** are highly effective in preventing caries in the chewing surfaces of molars where most caries occur. Among children at risk for caries, sealants should be placed on the permanent molars soon after they appear in the mouth (about age 6 for 1st molars). This measure assesses the percentage of children at elevated risk for dental caries who received a sealant on a first permanent molar. Median state performance on the SEAL-CH measure did not change significantly between FFY 2016 and FFY 2018.

The trends in performance for the two Child Core Set measures under the Dental and Oral Health Services domain are shown in the chart below.



Source: Mathematica analysis of FFY 2016-2018 MACPro reports and FFY 2016–2018 Form CMS-416 reports.

Notes: This chart includes the states that reported each measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations for the Dental Sealant measure, the rate for the larger measure-eligible population was used. Data from previous years may be updated based on new information received after publication of the 2018 Chart Pack.

F. Data Limitations

CMS strives to improve the completeness and quality of state reporting of the Child and Adult Core Set measures. Starting with the FFY 2014 reporting cycle, CMS has conducted a systematic real-time data quality review and outreach process. As part of this process, CMS followed up with states on any concerns about data completeness and quality; in many cases, states corrected and clarified their Core Set data to improve data accuracy.

Despite CMS efforts, several factors may affect the completeness, accuracy, and comparability of data over time and across states. In particular, most measures are reported by a subset of states, as participation in the Medicaid and CHIP quality reporting program is voluntary at this time.

- All states and the District of Columbia voluntarily reported at least one Child Core Set measure for FFYs 2017 and 2018, an increase over 49 states and the District of Columbia in FFY 2016. There was a slight decrease in the number of states reporting at least half of the measures in FFY 2018, from 45 states in FFYs 2016 and 2017 to 43 states in FFY 2018. However, a quarter of states reported 14 or fewer measures, which limits CMS's ability to make national observations about the quality of care provided to children in Medicaid and CHIP.
- The number of states voluntarily reporting at least one Adult Core Set measure has increased since FFY 2016 (41 states) and has remained stable for FFY 2017 and FFY 2018 (45 states). The number of publicly reported measures has also increased over time: 16 out of 28 measures were publicly reported for FFY 2016, while 19 out of 30 measures were publicly reported for FFY 2017 and 23 out of 33 measures were publicly reported for FFY 2018. Although reporting has improved over time, it remains difficult to make national observations about the quality of care provided to adult Medicaid beneficiaries.

In addition, despite the availability of technical assistance and CMS's robust data quality review process, states may not always be able to adhere to the measure technical specifications due to challenges such as limited data availability, use of bundled claims for multiple services, differences in state coding processes, or variation in covered services in Medicaid and CHIP.

States may also differ in the populations included in the measures they report (such as Medicaid versus CHIP or managed care versus fee-for-service), often making it difficult to compare results from state to state. Many states also reported difficulty accessing data on services covered by Medicaid beneficiaries dually eligible for Medicare.

Additionally, there exists variation in the extent to which reported data have been validated across all states. Reporting through the MACPro system is intended to help address this uncertainty, as is the robust data quality review process. In particular, the MACPro reporting process requires states to systematically review their data before submitting it to CMS, and the data quality review process gives states another opportunity to validate data elements after they have submitted data to MACPro.

CMS continues to work with states to improve the accuracy and completeness of the data reported. In addition, CMS continues to explore methods to enhance the validation features in MACPro and to improve the data quality review and outreach process.

G. Future Directions for Quality Measurement and Improvement

CMS is continuing to enhance the collection, reporting, and use of the Child and Adult Core Set measures as the foundation of its quality improvement efforts. The Core Set measures are at the center of CMS's efforts to collaborate with states, managed care plans, and providers to improve quality for Medicaid and CHIP beneficiaries. Several initiatives currently underway will support these ongoing efforts.

CMS supports states in using Core Set measures to drive QI and innovation through defined topic areas such as maternal and infant health, oral health, prevention and health improvement, behavioral health care, and care for children and adolescents with special health care needs. These QI initiatives are intended to assist states in identifying levers for improvement that are tied to quality measures. CMS is focusing on a data-driven approach to help states prioritize specific areas in need of QI and evaluate the outcomes and effectiveness of such initiatives.

Furthermore, CMS has continued efforts with states to develop a system for reporting claims and utilization activity that could be used for advanced analytics to assess beneficiary access and enrollment, improve care quality, and improve program integrity.[178] Known as T-MSIS, it will provide policy makers, program administrators, and researchers access to standardized claims and utilization data that can generate timely reports on access, utilization, quality, and costs. CMS is working to make T-MSIS data available through a variety of data products, such as analytic files, data marts, routine reports, and systems accessibility. Additionally, CMS is exploring the use of T-MSIS to produce many of the Core Set measures to enhance the timeliness, completeness, and comparability of measures across states, as well as to reduce state burden for reporting quality measures.

CMS also is continuing to support efforts to capture, analyze, and use electronic health records (EHRs) for quality measurement and improvement. Since the passage of the Health Information for Technology and Economic Health (HITECH) Act in 2009, the rate of EHR adoption by providers treating Medicare and Medicaid beneficiaries, particularly hospitals, has increased substantially,[179] enabling providers to use electronic clinical data to identify and address quality issues.[180] HHS also funded the development and testing of a pediatric-specific EHR.[181] The

[178] Centers for Medicare & Medicaid Services, Medicaid and CHIP Data Collection Systems. Available at: https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html

[179] Office of the National Coordinator for Health Information Technology, Health IT Dashboard: Quick Stats. Available at: http://dashboard.healthit.gov/quickstats/quickstats.php

[180] Centers for Disease Control and Prevention, National Electronic Health Records Survey: 2015 State and National Electronic Health Record Adoption Summary Tables. Available at: http://www.cdc.gov/nchs/data/ahcd/nehrs/2015_nehrs_web_table.pdf

[181] Agency for Healthcare Research and Quality, New Children's Electronic Health Record Format Announced, Feb 6, 2013. Available at: http://www.ahrq.gov/news/newsroom/press-releases/2013/childehrpr.html

increasingly widespread adoption of EHRs holds promise for improving quality measurement. For example, more than 70 percent of providers with an EHR can electronically report immunization status to their local health care authority.[182] As the Child and Adult Core Sets increasingly include clinical quality measures requiring the use of EHRs, CMS will continue to support states, health plans, and providers to build the infrastructure to capture this information to enhance quality measurement and improvement in Medicaid and CHIP.

CMS also will continue to convene a multi-stakeholder work group to update and strengthen the Child and Adult Core Sets annually and to look for opportunities to align the Core Sets with other federal measurement efforts. In addition, CMS will continue to assess the need for new measures, such as those developed through the Pediatric Quality Measurement Program authorized under CHIPRA, as it seeks to include more indicators of clinical quality in the Child and Adult Core Sets.

H. Managed Care Performance Measures, 2018-2019 Reporting Cycle

As of July 1, 2017, approximately 82 percent of all Medicaid beneficiaries were enrolled in some form of managed care,[183] although the rate of managed care enrollment in states using a managed care delivery system varies widely. Forty-one states use a managed care delivery system for all or some of their Medicaid and/or CHIP beneficiaries. Those states who opt to provide services through managed care plans are required to contract with a qualified independent external quality review organization (EQRO) to conduct an annual external quality review (EQR).[184] The EQR assesses and monitors the quality of care provided to Medicaid and CHIP beneficiaries enrolled in managed care plans and identifies opportunities for quality improvement. [185,186]

Annual EQRs analyze and evaluate information on quality, timeliness, and access to the health care services that managed care plan types and their contractors furnish to Medicaid and CHIP enrollees. Managed care plan types include managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), and primary care case management (PCCM) entities.[187]

[182] Office of the National Coordinator for Health Information Technology, Health IT Dashboard: Quick Stats. Available at: http://dashboard.healthit.gov/quickstats/quickstats.php

[183] https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf

[184] For Medicaid managed care plans that have been accredited by a CMS-approved accrediting organization that uses standards comparable to the EQR protocols adopted by CMS and where other requirements are met, the State has the option to use data and activities by the accreditation organization rather than duplicating the data and activities with an EQRO. 42 C.F.R. § 438.360.

[185] More information about the Medicaid and CHIP managed care final rule is available at https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html

[186] For more information on state contract options for EQR, see 42 C.F.R. § 438.356 (as cross referenced at § 457.1250 for CHIP).

[187] For the purposes of these protocols, all references to PCCM entities should be assumed to refer to the applicable subset of PCCM entities described at 42 C.F.R. §§ 438.310(c)(2), and 457.1240(f).

The EQR must be completed by an external quality review organization (EQRO) that meets competence and independence requirements. Fifteen different EQROs conducted the annual EQRs for the 41 states with Medicaid and CHIP managed care plans, and four of these EQROs conducted reviews for multiple states during the 2018–2019 reporting cycle. The majority of EQR technical reports focused on physical health services, but some included information on other types of managed care services, such as behavioral health and oral health.[188, 189, 190]

All 41 states that contracted with managed care plans to provide Medicaid and CHIP managed care during the 2018–2019 reporting cycle included performance measures related to at least one of the following topics: primary care access and preventive care, maternal and perinatal care, care of acute and chronic conditions, behavioral health care, dental and oral health services, and experience of care (Table 7).[191,192]

Table 8 shows the most frequently reported performance measure topics for the 2018–2019 reporting cycle. The performance measures reported during the 2018–2019 reporting cycle showed considerable overlap with both the Child and Adult Core Sets and the Healthcare Effectiveness Data and Information Set (HEDIS®), though CMS does not require the use of these measure sets. HEDIS measures are commonly included in state managed care contracts and validated by EQROs.

The most frequently reported Child and Adult Core Set and HEDIS measures reported by EQROs during the 2018–2019 reporting cycle were:

- **Primary Care Access and Preventive Care:** Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) (32 states); Childhood Immunization Status (CIS-CH) (29 states); Well-Child Visits in the First 15 Months of Life (W15-CH) and Adolescent Well-Care Visits (AWC-CH) (each reported by 28 states); and Children and Adolescents' Access to Primary Care Providers (CAP-CH) (27 states)
- **Care of Acute and Chronic Conditions:** Comprehensive Diabetes Care (31 states)

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

[189] EQR reports must be submitted to CMS by April 30 of each year to facilitate public reporting of EQR findings. The 2018–2019 reporting cycle includes states submitting reports between May 1, 2018 and April 30, 2019. These reports generally cover care delivered during CY 2017 and CY 2018.

[190] During the 2018-2019 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: Alabama, Alaska, Arkansas, Connecticut, Guam, Maine, Montana, Oklahoma, and the Virgin Islands. In addition, Idaho and Puerto Rico did not submit an EQR technical report before May 31, 2019 for inclusion in this analysis. 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 PIHP.

[191] The 41 states included AZ, CA, CO, DC, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI, WV, and WY.

[192] The 2016 Medicaid and CHIP managed care rule applied EQR to a broader range of Medicaid MCPs, that is, beyond MCOs and PIHPs to also include PAHPs and PCCM entities whose contracts with the state provide for shared savings, incentive payments or other financial reward for the PCCM entity for improved quality outcomes. The analysis of EQR reports for reporting year 2019-2020 will expand to include performance measures and PIPs reported by these plans.

- **Maternal and Perinatal Health:** Prenatal and Postpartum Care (PPC-CH/AD) (29 states)

While 41 states are required to produce an EQR technical report in the 2018-2019 reporting cycle, in each of the last three reporting cycles (2016–2017, 2017–2018, and 2018–2019), 37 states submitted an EQR technical report in each of the three reporting cycles. (Figure 8).[193] Between 2016-2017 and 2018-2019:

- The number of states reporting CAHPS measures increased from 23 to 26 states.
- The number of states reporting oral health and asthma/COPD measures increased from 27 to 29 states. The number of states reporting measures related to well-child care visits, weight/BMI, primary care access, sexually transmitted infections, cardiac care, and diabetes care measures increased by one state each, from 31 to 32, 29 to 30, 22 to 23, 28 to 29, and 31 to 32, respectively.
- The number of states reporting measures related to ADHD follow-up care, pharyngitis, and ED visits decreased by one state each, from 21 to 20, 13 to 12, and 21 to 20, respectively.

I. Managed Care Performance Improvement Projects (PIPs), 2018-2019 Reporting Cycle

All of the 41 states that submitted EQR technical reports for the 2018–2019 reporting cycle included at least one PIP, for a total of 882 PIPs (Table 9). Eighty-four percent of PIPs were validated and the number of PIPs varied among states by Core Set domain.

- The most common PIP topic pertained to "Care of Acute and Chronic Conditions," where 33 states reported a total of 256 PIPs.
    - 15 states reported a total of 55 diabetes prevention and treatment PIPs, 14 states reported a total of 41 PIPs focused on improving care transitions, and 13 states reported a total of 64 PIPs aimed at reducing ED visits.
- The second most common PIP topic pertained to "Behavioral Health Care," where 31 states reported a total of 241 PIPs.
    - 29 states reported a total of 180 PIPs focused on depression and follow-up after hospitalization, 11 states reported a total of 35 PIPs on substance use, and 5 states reported a total of 29 PIPs focused on tobacco.
- The third most common PIP topic pertained to "Primary Care Access and Preventive Care," where 28 states reported a total of 204 PIPs.
    - 17 states reported a total of 51 PIPs on well-child care, 10 states reported a total of 25 PIPs focused on primary care access, and 7 states reported a total of 18 PIPs related to cancer screening.

[193] States that submitted reports in all three reporting periods are: AZ, CA, CO, DE, DC, FL, GA, HI, IL, IN, KS, KY, LA, MD, MA, MI, MN, MS, MO, NV, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, TN, TX, UT, VA, WA, WVA, WI.

As Medicaid and CHIP managed care enrollment continues to increase, CMS recognizes the growing importance of state EQR activities, especially the role of PIPs as a vehicle for driving improvement. CMS will continue to work with states, managed care plans, EQROs, and health care providers to ensure effective implementation of the EQR protocols and compliance with the 2016 managed care rule.

IV. LEGISLATIVE RECOMMENDATIONS

As part of this Report to Congress, the Secretary of HHS is directed to include any recommendations for legislative changes needed to improve the quality of care provided to children and adults under Titles XIX and XXI, including recommendations for quality reporting by states.[194]

To ensure optimal reporting and quality improvement on the most relevant and reasonable to report quality measures, HHS respectfully requests consideration of legislative changes to reporting requirements with the aim of easing the reporting burden on states while still allowing HHS to gain important information to help drive quality improvement for Medicaid and CHIP beneficiaries. As mandatory reporting for the Child Core Set and the behavioral health measures of the Adult Core Set approaches in 2024, ensuring the measures are desirable, feasible, and viable is increasingly important.

Specifically, HHS recommends future legislation that funds and defines a comprehensive approach to quality that supports children and adults equally, and helps build state infrastructure for reporting quality measures. Ten years of Medicaid and CHIP quality reporting has revealed a discrepancy in reporting capacity based on service delivery models in a state. Due to managed care compliance requirements, states that offer services through managed care have traditionally had more robust reporting mechanisms than states that offer fee-for-service care delivery.

HHS recommends that future legislation supports mandatory reporting and funding for the complete adult quality measures program, and not limit focus to behavioral health measures, to make it consistent with mandatory reporting and current funding for the pediatric quality measures program.

In 2018, Congress provided $150 million in additional Federal funds to support the Medicaid and CHIP pediatric quality measures through section 3003 of the HEALTHY KIDS Act and section 50102 of the ACCESS Act. In addition, the ACCESS Act includes mandatory state reporting on the Child Core Set, beginning in FFY 2024.

HHS recommends funding quality measures programs for adults and children at the same levels, to adequately support states for quality measure collection, reporting, analysis and quality improvement related efforts for Medicaid and CHIP programs. There has been no legislation proposed to require reporting on the complete Adult Core Set, which was established in 2010 through the ACA, and there has not been allocation of additional funds since the original funds were established. Those funds are estimated to run out in FFY 2022.

Section 5001 of the SUPPORT Act for Parents and Communities Act requires mandatory reporting of adult behavioral health measures starting in 2024; however, it does not include appropriated funds to maintain and improve the Adult Core Set. Without additional financial support for the Adult Core Set, there is significant concern that state and federal reporting efforts will decline.

[194] Section 1139A(a)(6)(C) of the Social Security Act.

In addition, HHS recommends that reporting on the entire Adult Core Set should become mandatory in order to have continuity across both the child and adult quality measure programs and to drive quality improvement for all beneficiaries enrolled in state Medicaid and CHIP programs. HHS also recommends the inclusion of clarifying language that would allow HHS to use national data sources to report the measures on behalf of states to decrease reporting burden.

Lastly, to better support state analytic and quality improvement success, CMS encourages dedicated Congressional investments in federal and state data linkage initiatives, including state health information exchange activities and using data to drive improvements in care and health outcomes. A national evaluation of the CHIPRA Demonstration Grant program identified a number of lessons learned, including the need for states to strategically enhance their technological infrastructure and establish clearly defined methods for linking data. While HITECH investments have improved the ability for providers to share information with each other for care coordination purposes, greater investments are required at the state level to help Medicaid and CHIP agencies leverage that information for quality improvement and measurement at both the state and sub-state level. Investments to facilitate data linkage between Medicaid/CHIP information systems and public health information systems such as vital records and immunization registries would further promote the availability of data for quality improvement and measurement efforts. CMS has significantly expanded technical assistance to states for supporting data linkage, data streamlining from multiple sources, and measure alignment across programs. Considering Medicaid and CHIP programs provide coverage to more beneficiaries than Medicare and the Marketplace combined, HHS recommends that Congress provide consistent support to states to use data to drive continuous improvements in care and health outcomes for these programs.

These recommendations will support national and state efforts to assure accessible and high quality care for both adults and children eligible for Medicaid and CHIP.

V. CONCLUSION

As this report highlights, CMS has undertaken significant efforts between 2017 and 2019 to advance the quality of health care for children and adults enrolled in Medicaid and CHIP as well as to improve the Medicaid and CHIP programs. Highlights of CMS and states' efforts during this period include:

- Developed and implemented strategies to transform Medicaid and CHIP through focus on flexibility, accountability and integrity
- Created and implemented the Medicaid and CHIP Scorecard
- Improved efficiency of state eligibility and enrollment processes and systems
- Improved timeliness and accuracy in processing of state plan amendments and section 1915 waivers
- Implemented activities to improve maternal and infant health
- Implemented a broad range of activities to improve behavioral health care, including efforts to address substance use disorder and the opioid epidemic

CMS has worked closely with states to improve state reporting on the Medicaid and CHIP Child and Adult Core Sets. In FFY 2018, CMS publicly reported performance on 23 of the 26 Child Core Set measures, which was an increase from public reporting of 21 of 26 measures in FFY 2016 and 20 of 27 measures in FFY 2017. In FFY 2018, CMS publicly reported 23 of the 33 Adult Core Set measures, including reporting of 4 measures that were publicly reported for the first time. This was an increase in public reporting from 16 of 28 measures in FFY 2016 and 19 of 30 measures in FFY 2017.

CMS conducts a variety of activities to support states in their voluntary reporting through the Technical Assistance and Analytic Support (TA/AS) for the Medicaid and CHIP Quality Measurement and Improvement Program. CMS supports state efforts to collect, report, and use the Child and Adult Core Set measures for quality improvement. Since January 2017, the TA/AS team has responded to more than 700 inquiries, many of which pertain to measure calculation, data sources, and measurement periods. CMS also hosts webinars that cover critical components of Core Set reporting and provide targeted assistance on key topics or new measures.

Analysis of state performance on the Medicaid and CHIP Child and Adult Core Set measures suggests that performance continues to improve as demonstrated by statistically significant increases in the median rates in a number of quality measures that were eligible for trending over the 3-year period. For the Child Core Set, there were significant increases in the median rates for the well-care visits; immunizations for adolescents; developmental screening; chlamydia screening for women between the ages of 16 and 20; and monitoring of body mass index. There were also significant increases in the median rates for the following measures in the Adult Core Set: monitoring of body mass index; prenatal and postpartum care: postpartum care; and diabetes screening of people with schizophrenia or bipolar disorder. The only statistically significant decline in performance was found in the rate of inpatient hospital admissions for heart failure measure included in the Adult Core Set.

CMS works with states to improve data quality and to use measurement to drive quality improvement. In addition, CMS encourage states to use data linkages and to move beyond claims-based data for the reporting of Medicaid and CHIP Child and Adult Core Set measures.

As CMS and states move towards mandatory reporting of Child Core Set measures and behavioral health Adult Core Set measures in 2024, it is essential that CMS and states work together to improve quality reporting. CMS is committed to providing tailored technical assistance to states in order to support their efforts to improve quality and completeness of data as well as to obtain improved health outcomes for Medicaid and CHIP beneficiaries.

FIGURES

Figure 1. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2016–2019

NQF #	Measure Steward	Measure Name	2016	2017	2018	2019
Primary Care Access and Preventive Care						
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)	X	X	X	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	X	X	X
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)[a]	--	--	X	X
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	X	X	X	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	X	X	X
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	X	X	X	X
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	X	X	X	X
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV-CH)[b]	X	--	--	--
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	X	X	X	X
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)	X	X	X	X
Maternal and Perinatal Health						
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	X	X	X	X
0471	TJC	PC-02: Cesarean Birth (PC02-CH)	X	X	X	X
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)[c]	X	X	X	X
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	X	X	X	X
1391*	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)[d]	X	X	--	--
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)[e]	--	X	X	X
2903/2904	OPA	Contraceptive Care – All Women Ages 15–20 (CCW-CH)[f]	--	--	X	X
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)[g]	X	X	--	--
Care of Acute and Chronic Conditions						
1799*	NCQA	Medication Management for People with Asthma (MMA-CH)[h]	X	X	--	--

Figure 1. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2016–2019 (continued)

NQF #	Measure Steward	Measure Name	2016	2017	2018	2019
1800	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)[h]	--	--	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	X	X	X
Behavioral Health Care						
0108	NCQA	Follow-Up Care for Children Prescribed Attention- Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)[i]	X	X	X	X
1365	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)[j]	X	X	--	--
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[k]	--	X	X	X
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[l]	X	X	X	X
Dental and Oral Health Services						
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	X	X	X	X
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	X	X	X	X
Experience of Care						
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	X	X	X	X

X = Included in Child Core Set; -- = Not Included in Child Core Set.

AAO-HNSF = American Academy of Otolaryngology-Head and Neck Surgery; AMA = American Medical Association; CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; PCPI = Physician Consortium for Performance Improvement; TJC = The Joint Commission.

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

*This measure is no longer endorsed by NQF.

[a] The Screening for Depression and Follow-Up Plan: Ages 12 –17 measure was added to the 2018 Child Core Set to align with the Adult Core Set and replace the Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure as a broader measure of behavioral health.

[b] The stand-alone HPV Vaccine for Female Adolescents measure was retired by the measure steward, and added to the Immunizations for Adolescents measure beginning with the 2017 Child Core Set.

[c] The Audiological Diagnosis No Later Than 3 Months of Age measure was added to the 2016 Child Core Set due to opportunities for quality improvement on the measure and its alignment with the electronic health record incentive program.

[d] The Frequency of Ongoing Prenatal care measure was retired from the Child Core Set in 2018 because it does not assess the content of the prenatal care visit.

[e] The Contraceptive Care – Postpartum Women Ages 15–20 measure was added to the 2017 Child Core Set because it measures the provision of contraception to mothers in the postpartum period, which can help women space pregnancies to their desired interpregnancy interval and help to improve future birth outcomes.

Figure 1. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2016–2019 (continued)

[f] The Contraceptive Care – All Women Ages 15–20 measure was added to the 2018 Child Core Set to assess access to contraceptive care, which has an important role in promoting health equity.

[g] The Behavioral Health Risk Assessment (for Pregnant Women) measure was removed from the Child Core Set in 2018 due to implementation and data collection challenges. AMA-PCPI was the measure steward for the 2013-2016 Child Core Sets; the measure had no steward for the 2017 Child Core Set.

[h] Beginning with the 2018 Child Core Set, the Asthma Medication Ratio: Ages 5–18 measure replaces the Medication Management for People with Asthma measure, which was included in the 2013-2017 Child Core Sets.

[i] The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from ages 6 to 20 to ages 6 to 17 for the 2019 Child Core Set.

[j] The Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure was added to the 2015 Child Core Set to target a high prevalence mental health condition that has severe consequences without appropriate treatment. The measure was removed from the Child Core Set in 2018 because of the need for a broader measure of behavioral health.

[k] The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure was added to the 2017 Child Core Set to promote the use of nonpharmacologic, evidence-informed approaches to the treatment of mental and behavioral health problems of Medicaid and CHIP insured children on psychotropic medications.

[l] The Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure was added to the 2016 Child Core Set to target inappropriate prescribing of antipsychotic medications, which may have adverse health effects.

Figure 2. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2016–2019

NQF #	Measure Steward	Measure Name	2016	2017	2018	2019
Primary Care Access and Preventive Care						
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 21–24 (CHL-AD)	X	X	X	X
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	X	X	X
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	X	X	X	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)	X	X	X	X
Maternal and Perinatal Health						
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	X	X	X	X
0476	TJC	PC-03: Antenatal Steroids (PC03-AD)[a]	X	X	X	--
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)[b]	--	X	X	X
2903/2904	OPA	Contraceptive Care – All Women Ages 21–44 (CCW-AD)[c]	--	--	X	X
Care of Acute and Chronic Conditions						
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	X	X	X	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	X	X	X	X
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	X	X	X	X
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	X	X	X
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	X	X	X	X
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	X	X	X
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	X	X	X	X
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X
1800	NCQA	Asthma Medication Ratio: Ages 19–64 (AMR-AD)[d]	--	--	X	X
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)	X	X	X	X

Figure 2. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2016–2019 (continued)

NQF #	Measure Steward	Measure Name	2016	2017	2018	2019
Behavioral Health Care						
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	X	X	X	X
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	X	X	X
0105	NCQA	Antidepressant Medication Management (AMM-AD)	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[e]	X	X	X	X
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[f]	X	X	X	X
2605	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)[g]	--	X	X	X
2605	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[g]	--	X	X	X
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[h]	--	X	X	X
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[e]	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[i]	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[j]	--	--	X	X
Care Coordination						
0648*	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR-AD)[k]	X	--	--	--
Experience of Care						
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)[l]	X	X	X	X

X = Included in Adult Core Set; -- = Not Included in Adult Core Set.

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

*This measure is no longer endorsed by NQF.

[a] The Antenatal Steroids measure was retired from the Adult Core Set in 2019 due to the low number of states reporting this measure and the challenges states have described in collecting it.

[b] The Contraceptive Care – Postpartum Women Ages 21–44 measure was added to the 2017 Adult Core Set because it measures the provision of contraception to mothers in the postpartum period, which can help women space pregnancies to their desired interpregnancy interval and help to improve future birth outcomes.

Figure 2. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2016–2019 (continued)

[c] The Contraceptive Care – All Women Ages 21–44 measure was added to the 2018 Adult Core Set to assess access to contraceptive care, which has an important role in promoting health equity.

[d] The Asthma Medication Ratio: Ages 19–64 measure was added to the 2018 Adult Core Set and aligns with changes made to the 2018 Child Core Set.

[e] The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from age 21 and older to age 18 and older for the 2019 Adult Core Set.

[f] Two measures focused on quality of care for adults with substance use disorders and/or mental health disorders were added to the 2016 Adult Core Set: (1) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population; and (2) Use of Use of Opioids at High Dosage in Persons Without Cancer is a measure of potential overuse that addresses the epidemic of narcotic morbidity and mortality.

[g] The Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (FUA/FUM-AD) measure was added to the 2017 Adult Core Set because it addresses priority areas of access and follow-up of care for adults with mental health or substance use disorders. In the 2017 and 2018 Adult Core Sets, this was included as a single measure (FUA/FUM-AD). For the 2019 Adult Core Set, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) and Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) are included as two separate measures.

[h] The Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was added to the 2017 Adult Core Set because it addresses chronic disease management for people with serious mental illness, and assesses integration of medical and behavioral services by reinforcing shared accountability and linkage of medical and behavioral healthcare services.

[i] The Adult Core Set includes the NCQA version of the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure, which is adapted from the CMS measure (NQF #1879).

[j] The Concurrent Use of Opioids and Benzodiazepines measure was added to the 2018 Adult Core Set because it addresses early opioid use and polypharmacy.

[k] The Timely Transmission of Transition Record measure was retired from the Adult Core Set in 2017 due to the low number of states reporting this measure, a decrease in the number of states reporting over time, and the challenges states have described in collecting it.

[l] The Adult Core Set includes the NCQA version of the CAHPS® Health Plan Survey 5.0H, Adult Version (Medicaid) measure, which is adapted from the AHRQ measure (NQF #0006).

Figure 3. Number of Child Core Set Measures Reported by States, FFY 2016–2018

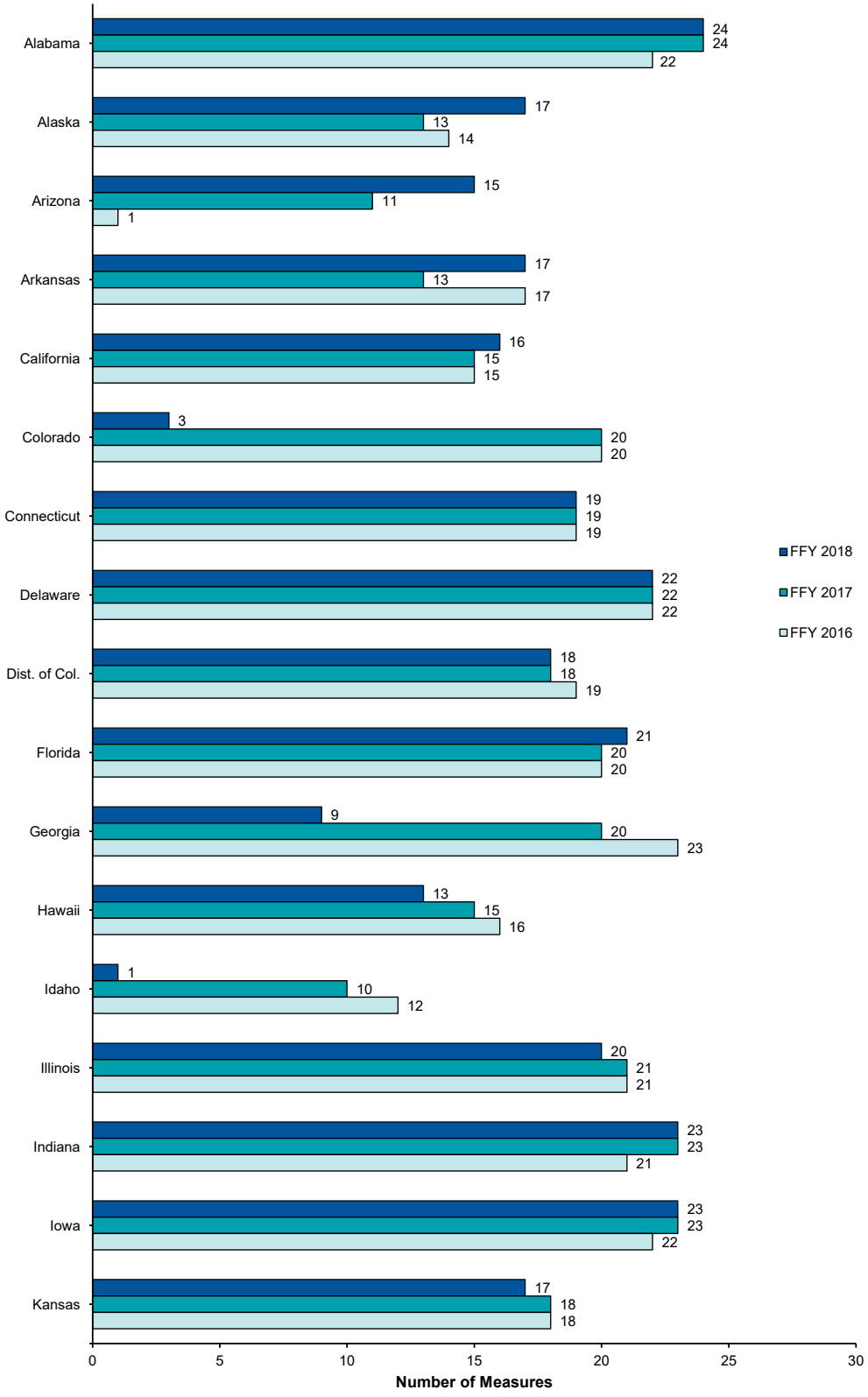


Figure 3. Number of Child Core Set Measures Reported by States, FFY 2016–2018 (continued)

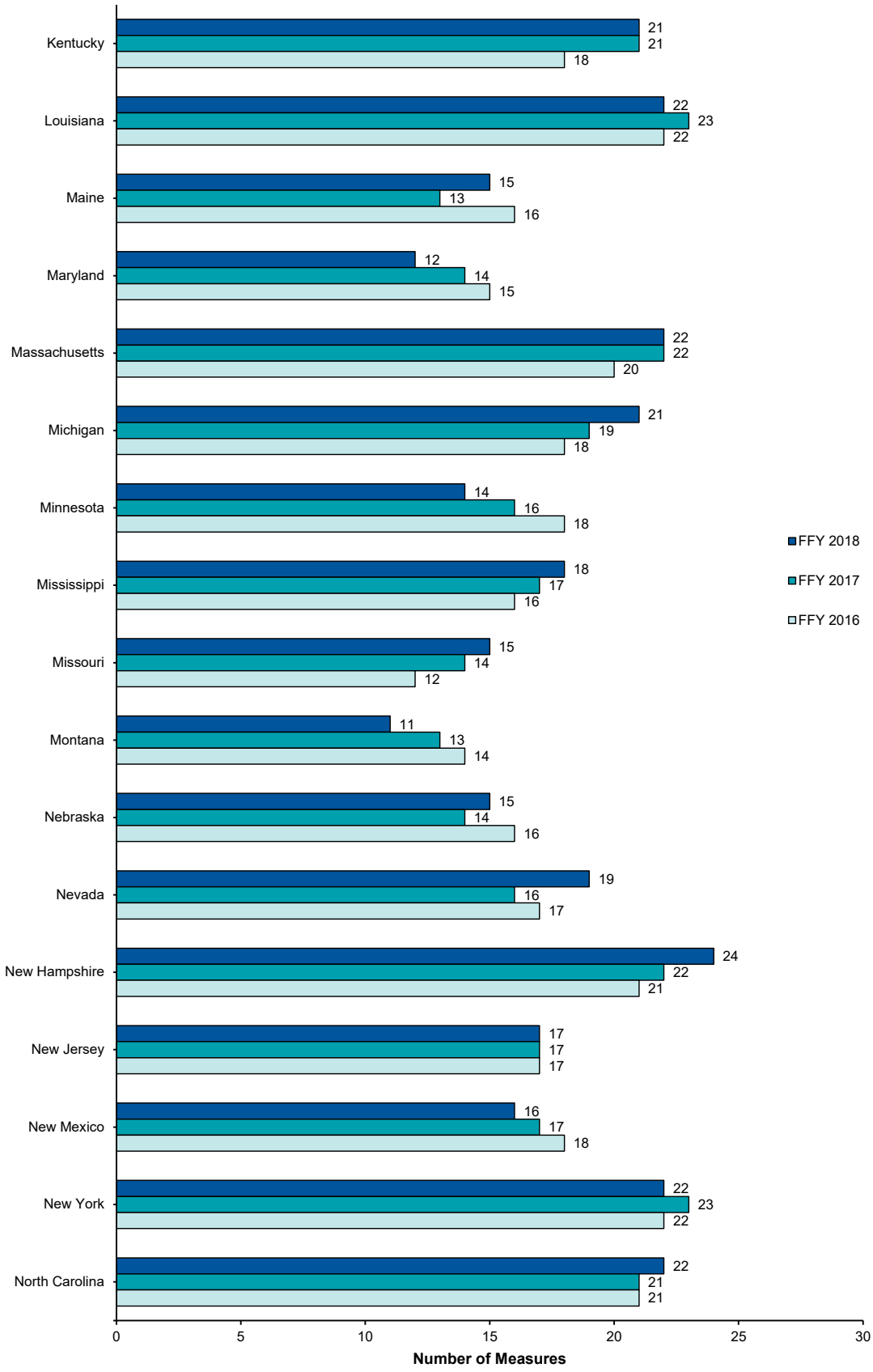
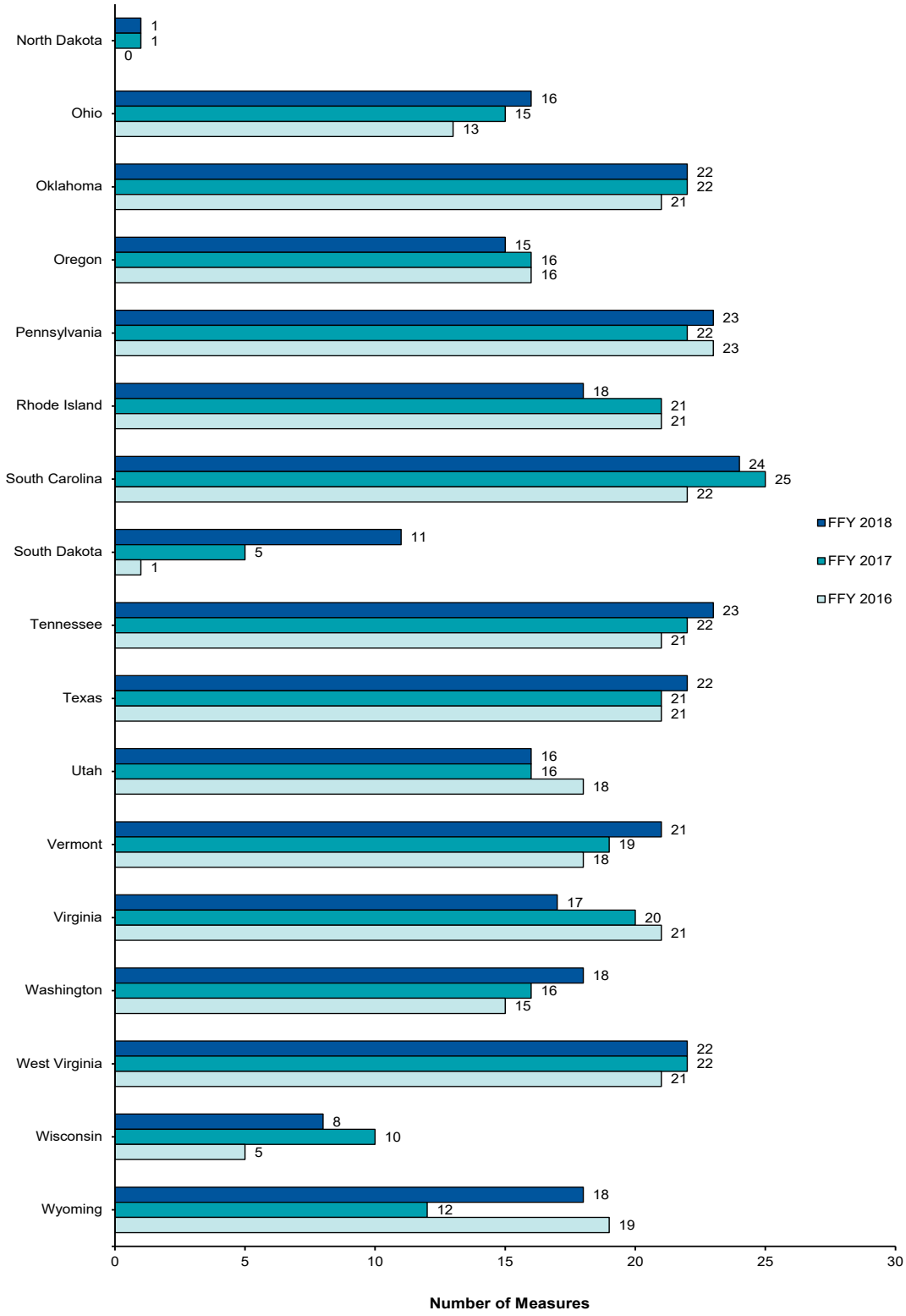


Figure 3. Number of Child Core Set Measures Reported by States, FFY 2016–2018 (continued)



Sources: Mathematica analysis of FFY 2016–2018 MACPro reports and Form CMS-416 reports.

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

The Child Core Set varies slightly from year to year. See text for details.

Figure 4. Number of States Reporting the Child Core Set Measures, FFY 2016–2018

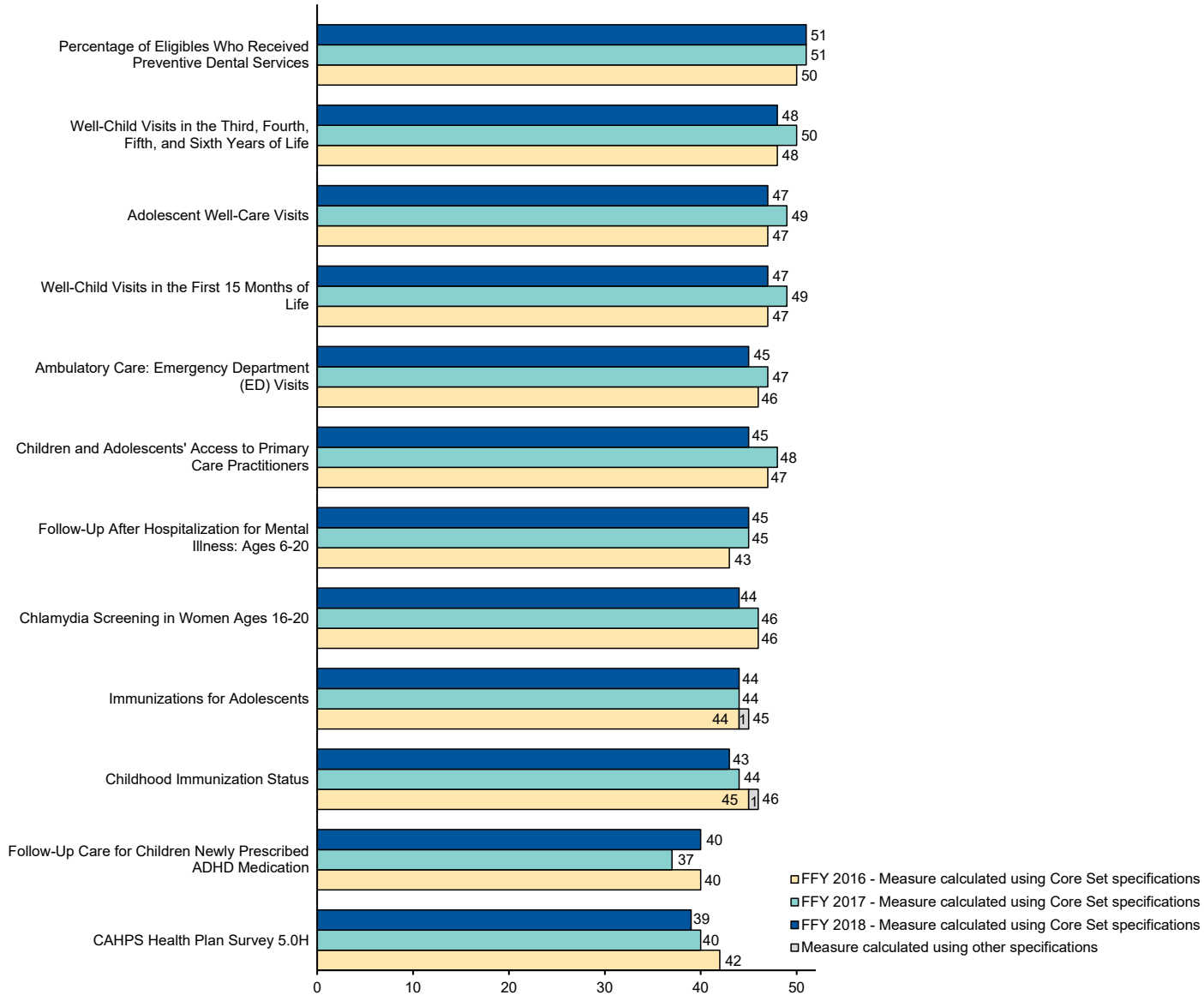


Figure 4. Number of States Reporting the Child Core Set Measures, FFY 2016–2018 (continued)

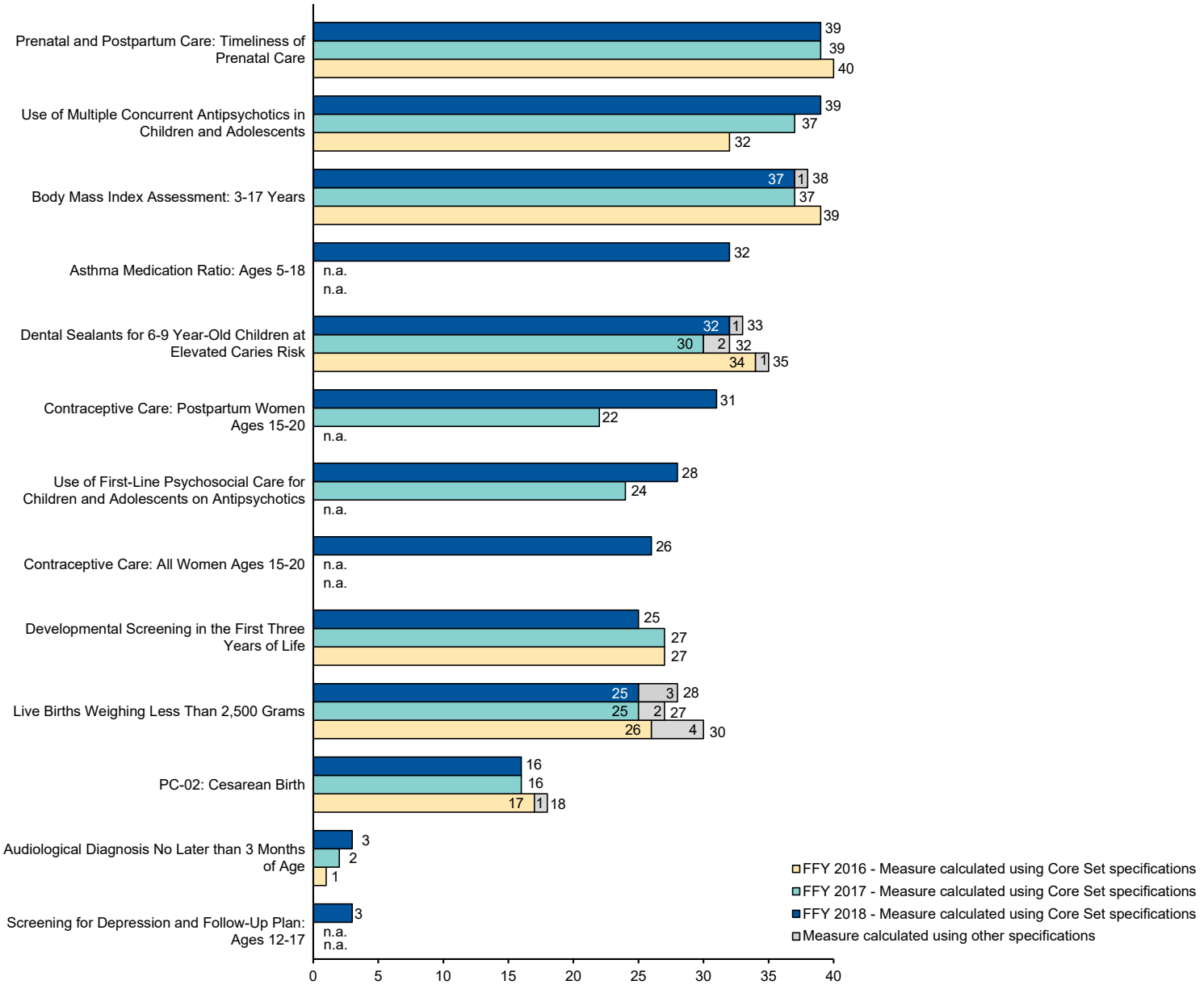


Figure 4. Number of States Reporting the Child Core Set Measures, FFY 2016–2018 (continued)

Sources: Mathematica analysis of FFY 2016–2018 MACPro reports and Form CMS-416 reports.

Notes: The term "states" includes the 50 states and the District of Columbia. The 2018 Child Core Set includes 26 measures. This chart excludes the CLABSI measure, which is obtained from CDC's National Healthcare Safety Network.

This chart includes all Child Core Set measures that states reported for the FFY 2018 reporting cycle. Unless otherwise specified, states used Child Core Set specifications to calculate the measures. Some states calculated Child Core Set measures using "other specifications." Measures were denoted as using "other specifications" when the state deviated substantially from the Child Core Set specifications, such as using alternate data sources, different populations, or other methodologies. Data from previous years may be updated based on new information received after publication of earlier reports.

n.a. = not applicable; measure not included in the Child Core Set for the reporting period.

Figure 5. Number of Adult Core Set Measures Reported by States, FFY 2016–2018

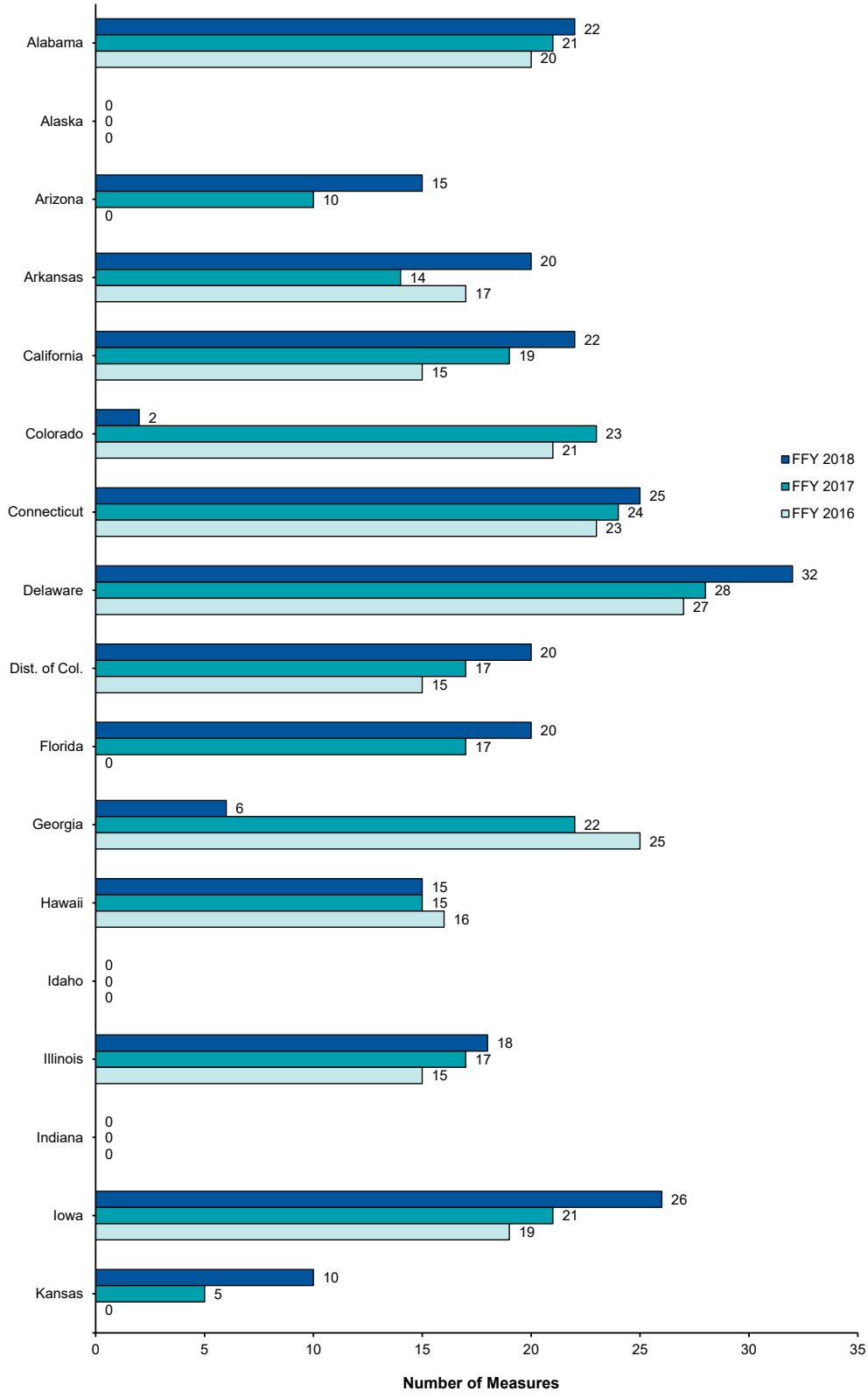


Figure 5. Number of Adult Core Set Measures Reported by States, FFY 2016–2018 (continued)

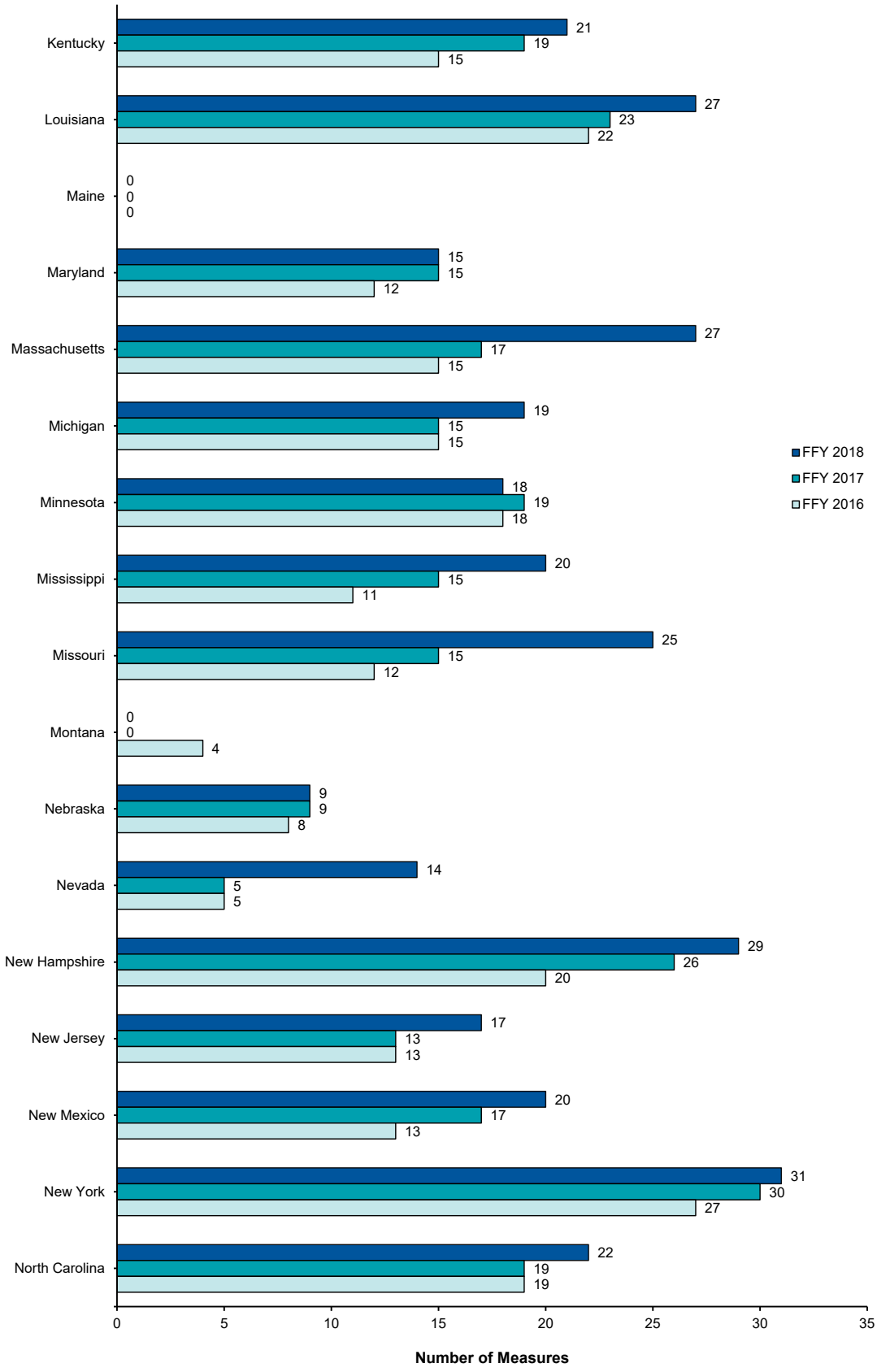
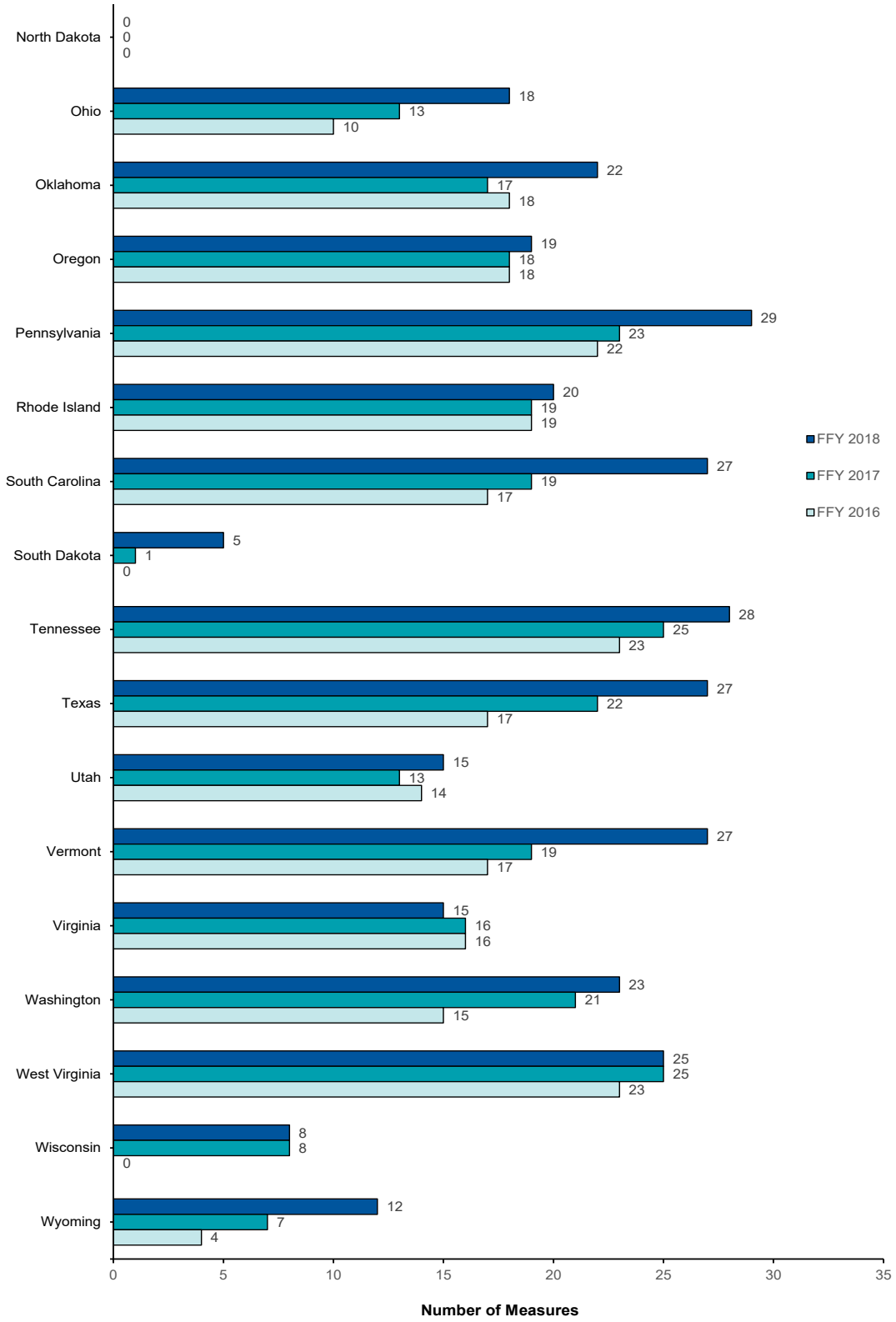


Figure 5. Number of Adult Core Set Measures Reported by States, FFY 2016–2018 (continued)



Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: The term "states" includes the 50 states and the District of Columbia.
The Adult Core Set varies slightly from year to year. See text for details.

Figure 6. Number of States Reporting the Adult Core Set Measures, FFY 2016–2018

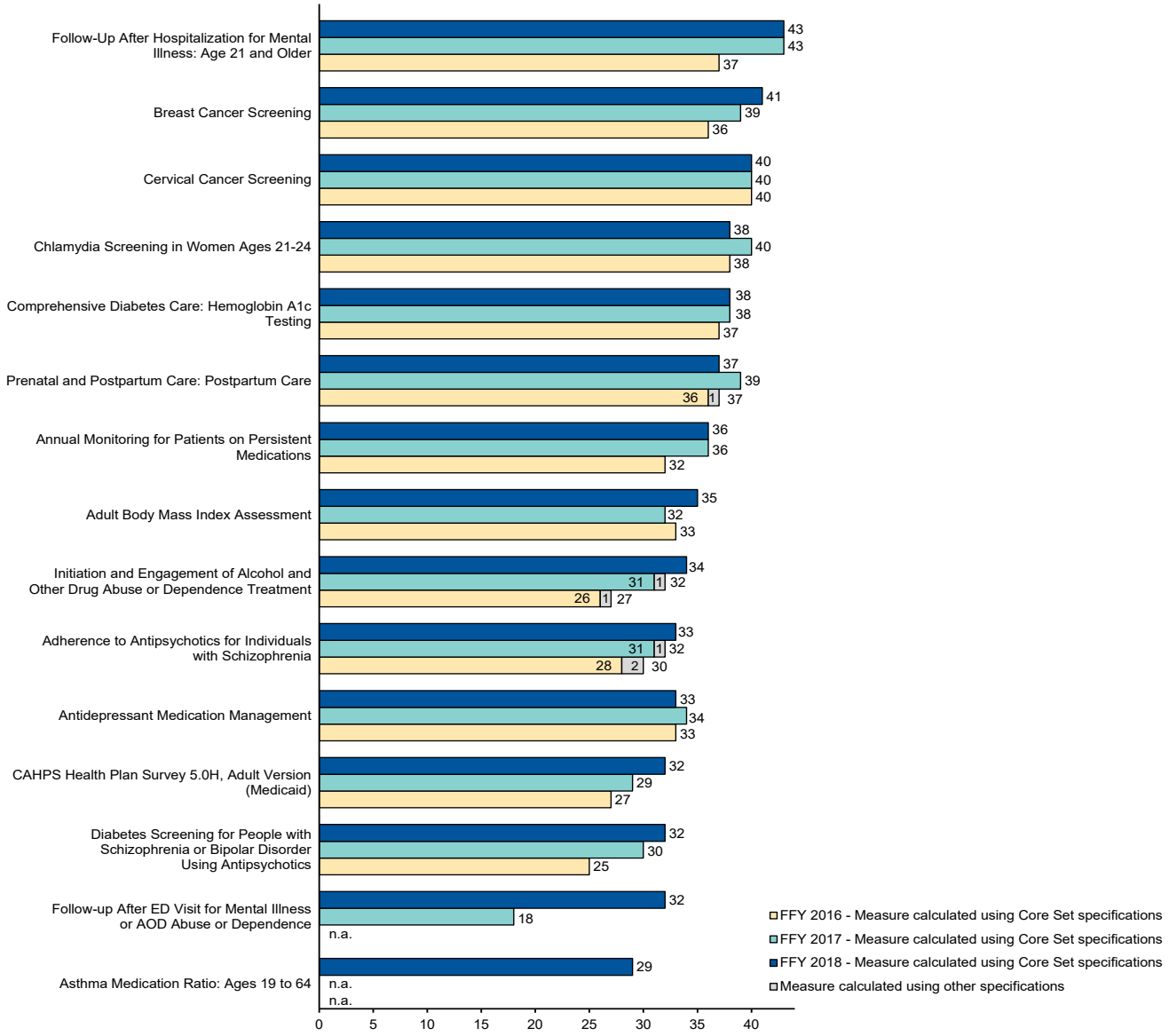


Figure 6. Number of States Reporting the Adult Core Set Measures, FFY 2016–2018 (continued)

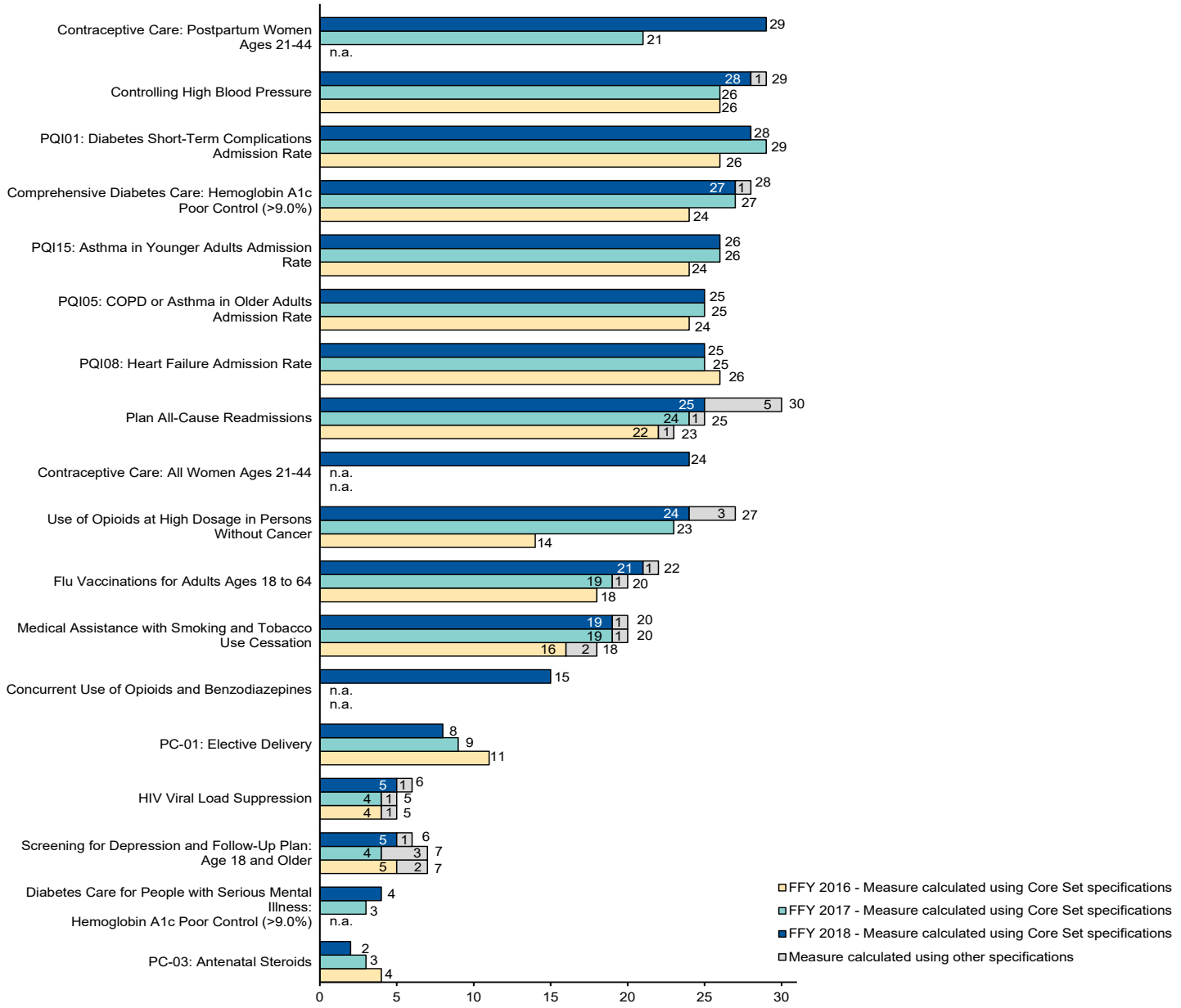


Figure 6. Number of States Reporting the Adult Core Set Measures, FFY 2016–2018 (continued)

Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

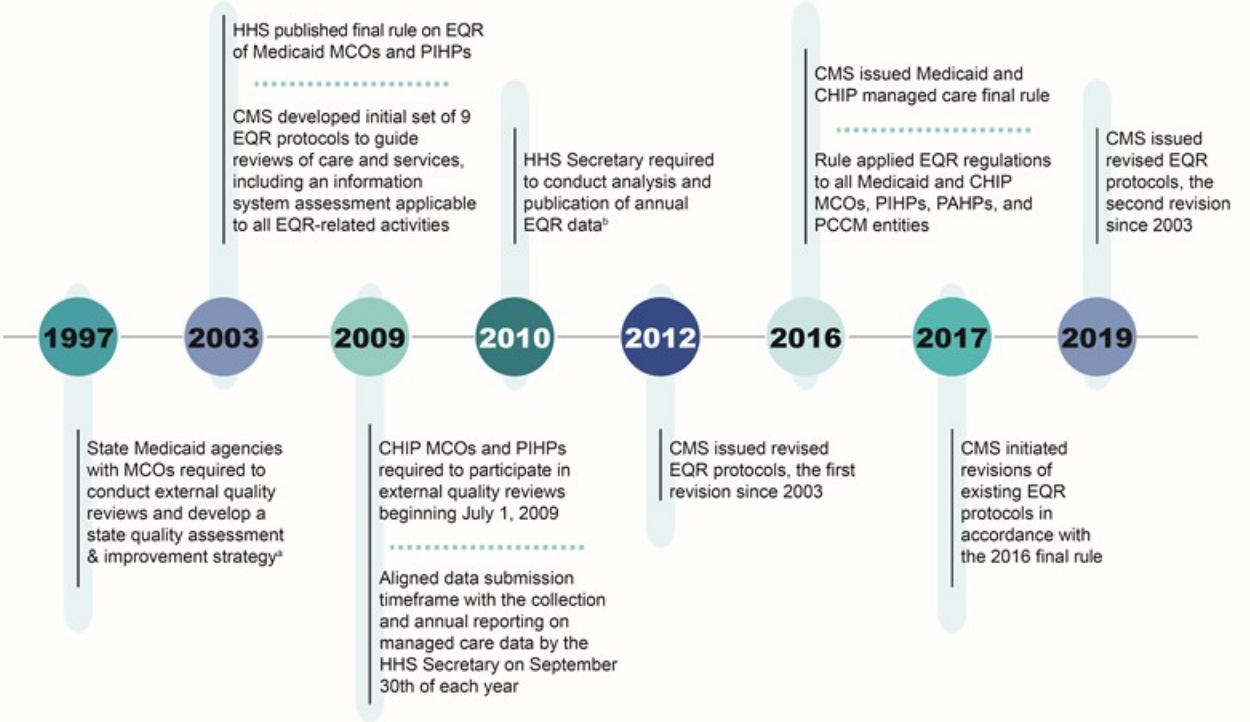
Notes: The term "states" includes the 50 states and the District of Columbia. The 2018 Adult Core Set includes 33 measures.

This chart includes all Adult Core Set measures that states reported for the FFY 2018 reporting cycle. Unless otherwise specified, states used Adult Core Set specifications to calculate the measures. Some states calculated Adult Core Set measures using "other specifications." Measures were denoted as using "other specifications" when the state deviated substantially from the Adult Core Set specifications, such as using alternate data sources, different populations, or other methodologies. Data from previous years may be updated based on new information received after publication of earlier reports.

AOD = Alcohol and Other Drug; COPD = Chronic Obstructive Pulmonary Disease; ED = Emergency Department.

n.a. = not applicable; measure not included in the Adult Core Set for the reporting period.

Figure 7. Evolution of EQR in Medicaid and CHIP



Notes: CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; EQR = external quality review; HHS = U.S. Department of Health & Human Services; MCOs = managed care organizations; PAHPs = prepaid ambulatory health plans; PCCM = primary care case management; PIHPs = prepaid inpatient health plans.

[a] Balanced Budget Act of 1997 amending section 1932(c)(1)(B) of the Social Security Act.

[b] Section 1139A(c)(2) of the Social Security Act, as amended by section 401(a) of CHIPRA, requires the HHS Secretary to summarize State-specific information on the quality of health care furnished to children under titles XIX (Medicaid) and XXI (CHIP). Section 1139A(c)(1)(B) of the Act specifically requests information gathered from the external quality reviews of managed care organizations (MCOs) and benchmark plans.

Figure 8. Comparison of Performance Measures Evaluating Health Care Quality Reported in External Quality Review (EQR) Technical Reports for the 2016–2017, 2017–2018, and 2018–2019 Reporting Cycles for 37 States, by General Topic

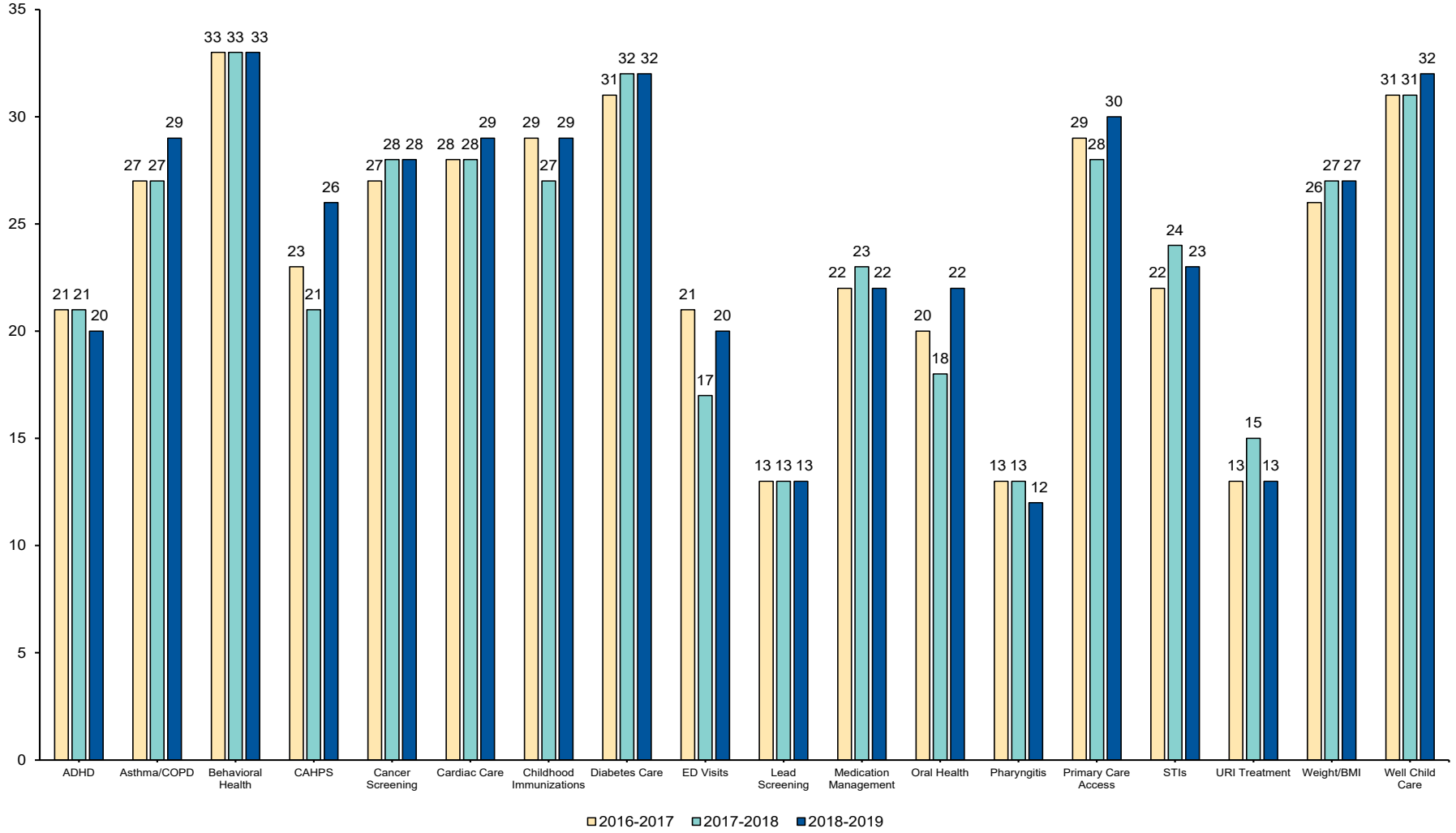


Figure 8. Comparison of Performance Measures Evaluating Health Care Quality Reported in External Quality Review (EQR) Technical Reports for the 2016–2017, 2017–2018, and 2018–2019 Reporting Cycles for 37 states, by General Topic (continued)

Source: EQR technical reports submitted to CMS for the 2018–2019 reporting cycle as of May 31, 2019. Performance measures for 2015-2016 and 2016-2017 are based on Mathematica analysis of EQR technical reports.

Notes: During the 2018–2019 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ME, MT, OK, and VI. In addition, ID and PR did not submit an EQR technical report before May 31, 2019 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. WY is CHIP-only.

Information about the EQR process is available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

States that submitted reports in all three reporting periods are: AZ, CA, CO, DE, DC, FL, GA, HI, IL, IN, KS, KY, LA, MD, MA, MI, MN, MS, MO, NV, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI, WV.

"Behavioral health" is used as an umbrella term that includes mental health, substance use disorder, and other behavioral conditions.

ADHD = attention deficit/hyperactivity disorder; 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; EQR = external quality review; MCO = managed care organization; PIHP = prepaid inpatient health plan; URI = upper respiratory infection.

TABLES

Table 1. Number of Child Core Set Measures Reported by States, FFY 2016–2018

State	Number of Measures Reported			Change in Number of Measures Reported FFY 2016–2018	Change in Number of Measures Reported FFY 2017–2018
	FFY 2016 (n = 26)	FFY 2017 (n = 27)	FFY 2018 (n = 26)		
Median	18	18	18	0	0
Alabama	22	24	24	2	0
Alaska	14	13	17	3	4
Arizona	1	11	15	14	4
Arkansas	17	13	17	0	4
California	15	15	16	1	1
Colorado	20	20	3	-17	-17
Connecticut	19	19	19	0	0
Delaware	22	22	22	0	0
Dist. of Col.	19	18	18	-1	0
Florida	20	20	21	1	1
Georgia	23	20	9	-14	-11
Hawaii	16	15	13	-3	-2
Idaho	12	10	1	-11	-9
Illinois	21	21	20	-1	-1
Indiana	21	23	23	2	0
Iowa	22	23	23	1	0
Kansas	18	18	17	-1	-1
Kentucky	18	21	21	3	0
Louisiana	22	23	22	0	-1
Maine	16	13	15	-1	2
Maryland	15	14	12	-3	-2
Massachusetts	20	22	22	2	0
Michigan	18	19	21	3	2
Minnesota	18	16	14	-4	-2
Mississippi	16	17	18	2	1
Missouri	12	14	15	3	1
Montana	14	13	11	-3	-2
Nebraska	16	14	15	-1	1
Nevada	17	16	19	2	3
New Hampshire	21	22	24	3	2
New Jersey	17	17	17	0	0
New Mexico	18	17	16	-2	-1
New York	22	23	22	0	-1
North Carolina	21	21	22	1	1
North Dakota	0	1	1	1	0
Ohio	13	15	16	3	1
Oklahoma	21	22	22	1	0
Oregon	16	16	15	-1	-1
Pennsylvania	23	22	23	0	1
Rhode Island	21	21	18	-3	-3
South Carolina	22	25	24	2	-1
South Dakota	1	5	11	10	6
Tennessee	21	22	23	2	1

Table 1. Number of Child Core Set Measures Reported by States, FFY 2016–2018 (continued)

State	Number of Measures Reported			Change in Number of Measures Reported FFY 2016–2018	Change in Number of Measures Reported FFY 2017–2018
	FFY 2016 (n = 26)	FFY 2017 (n = 27)	FFY 2018 (n = 26)		
Texas	21	21	22	1	1
Utah	18	16	16	-2	0
Vermont	18	19	21	3	2
Virginia	21	20	17	-4	-3
Washington	15	16	18	3	2
West Virginia	21	22	22	1	0
Wisconsin	5	10	8	3	-2
Wyoming	19	12	18	-1	6

Sources: Mathematica analysis of FFY 2016–2018 MACPro reports and Form CMS-416 reports.

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

The Child Core Set varies slightly from year to year as follows:

The 2016 Child Core Set, corresponding to reporting for FFY 2016, included 26 measures. Two measures were added to the 2016 Child Core Set: Use of Multiple Concurrent Antipsychotics in Children and Adolescents and Audiological Evaluation No Later Than 3 Months of Age. States reported up to 25 measures for FFY 2016; data for the Central Line-Associated Bloodstream Infection (CLABSI) measure were obtained from CDC.

The 2017 Child Core Set, corresponding to reporting for FFY 2017, included 27 measures. Two measures were added to the 2017 Child Core Set: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics and Contraceptive Care – Postpartum Women Ages 15-20. No measures were retired for the 2017 Child Core Set, but the Human Papillomavirus (HPV) Vaccine for Female Adolescents rate was added as a new rate under the Immunizations for Adolescents measure. States reported up to 26 measures for FFY 2017; data for the CLABSI measure were obtained from CDC.

The 2018 Child Core Set, corresponding to reporting for FFY 2018, included 26 measures. Three measures were added to the 2018 Child Core Set: Asthma Medication Ratio: Ages 5-18, Contraceptive Care – All Women Ages 15-20, and Screening for Depression and Follow-Up Plan: Ages 12 –17. Four measures were retired from the 2018 Child Core Set: Behavioral Health Risk Assessment (for Pregnant Women), Frequency of Ongoing Prenatal Care, Medication Management for People with Asthma, and Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment. States reported up to 25 measures for FFY 2018; data for the CLABSI measure were obtained from CDC.

Data from previous years may be updated based on new information received after publication of earlier reports.

Table 2. Number of States Reporting the Child Core Set Measures, FFY 2016–2018

Measure	Number of States Reporting			Change in Number of States Reporting FFY 2016–2018	Change in Number of States Reporting FFY 2017–2018
	FFY 2016	FFY 2017	FFY 2018		
Percentage of Eligibles Who Received Preventive Dental Services	50	51	51	1	0
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	48	50	48	0	-2
Adolescent Well-Care Visits	47	49	47	0	-2
Well-Child Visits in the First 15 Months of Life	47	49	47	0	-2
Ambulatory Care: Emergency Department (ED) Visits	46	47	45	-1	-2
Children and Adolescents' Access to Primary Care Practitioners	47	48	45	-2	-3
Follow-Up After Hospitalization for Mental Illness: Ages 6–20	43	45	45	2	0
Chlamydia Screening in Women Ages 16–20	46	46	44	-2	-2
Immunizations for Adolescents	45	44	44	-1	0
Childhood Immunization Status	46	44	43	-3	-1
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	40	37	40	0	3
CAHPS Health Plan Survey 5.0H	42	40	39	-3	-1
Prenatal and Postpartum Care: Timeliness of Prenatal Care	40	39	39	-1	0
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	32	37	39	7	2
Body Mass Index Assessment for Children/Adolescents	39	37	38	-1	1
Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk	35	32	33	-2	1
Asthma Medication Ratio: Ages 5–18	n.a.	n.a.	32	n.a.	n.a.
Contraceptive Care – Postpartum Women Ages 15–20	n.a.	22	31	n.a.	9
Live Births Weighing Less Than 2,500 Grams	30	27	28	-2	1
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	n.a.	24	28	n.a.	4
Contraceptive Care – All Women Ages 15–20	n.a.	n.a.	26	n.a.	n.a.
Developmental Screening in the First Three Years of Life	27	27	25	-2	-2
PC02: Cesarean Birth	18	16	16	-2	0

Table 2. Number of States Reporting the Child Core Set Measures, FFY 2016–2018 (continued)

Measure	Number of States Reporting			Change in Number of States Reporting FFY 2016–2018	Change in Number of States Reporting FFY 2017–2018
	FFY 2016	FFY 2017	FFY 2018		
Audiological Diagnosis No Later than 3 Months of Age	1	2	3	2	1
Screening for Depression and Follow-Up Plan: Ages 12-17	n.a.	n.a.	3	n.a.	n.a.
Human Papillomavirus Vaccine for Female Adolescents	42	n.a.	n.a.	n.a.	n.a.
Frequency of Ongoing Prenatal Care	33	34	n.a.	n.a.	n.a.
Behavioral Health Risk Assessment (for Pregnant Women)	6	5	n.a.	n.a.	n.a.
Medication Management for People with Asthma	41	40	n.a.	n.a.	n.a.
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	1	0	n.a.	n.a.	n.a.

Sources: Mathematica analysis of FFY 2016–2018 MACPro reports and Form CMS-416 reports.

Notes: The term “state” includes the 50 states and the District of Columbia.

The measures are sorted by the number of states reporting the measures for FFY 2018.

Data from previous years may be updated based on new information received after publication of earlier reports.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; n.a. = not applicable; measure was not reported in all three years.

Table 3. Number of Adult Core Set Measures Reported by States, FFY 2016–2018

State	Number of Measures Reported			Change in Number of Measures Reported FFY 2016–2018	Change in Number of Measures Reported FFY 2017–2018
	FFY 2016 (n = 28)	FFY 2017 (n = 30)	FFY 2018 (n = 33)		
Median	17	17	20	3	3
Alabama	20	21	22	2	1
Alaska	0	0	0	0	0
Arizona	0	10	15	15	5
Arkansas	17	14	20	3	6
California	15	19	22	7	3
Colorado	21	23	2	-19	-21
Connecticut	23	24	25	2	1
Delaware	27	28	32	5	4
Dist. of Col.	15	17	20	5	3
Florida	0	17	20	20	3
Georgia	25	22	6	-19	-16
Hawaii	16	15	15	-1	0
Idaho	0	0	0	0	0
Illinois	15	17	18	3	1
Indiana	0	0	0	0	0
Iowa	19	21	26	7	5
Kansas	0	5	10	10	5
Kentucky	15	19	21	6	2
Louisiana	22	23	27	5	4
Maine	0	0	0	0	0
Maryland	12	15	15	3	0
Massachusetts	15	17	27	12	10
Michigan	15	15	19	4	4
Minnesota	18	19	18	0	-1
Mississippi	11	15	20	9	5
Missouri	12	15	25	13	10
Montana	4	0	0	-4	0
Nebraska	8	9	9	1	0
Nevada	5	5	14	9	9
New Hampshire	20	26	29	9	3
New Jersey	13	13	17	4	4
New Mexico	13	17	20	7	3
New York	27	30	31	4	1
North Carolina	19	19	22	3	3
North Dakota	0	0	0	0	0
Ohio	10	13	18	8	5
Oklahoma	18	17	22	4	5
Oregon	18	18	19	1	1
Pennsylvania	22	23	29	7	6
Rhode Island	19	19	20	1	1
South Carolina	17	19	27	10	8
South Dakota	0	1	5	5	4
Tennessee	23	25	28	5	3

Table 3. Number of Adult Core Set Measures Reported by States, FFY 2016–2018 (continued)

State	Number of Measures Reported			Change in Number of Measures Reported FFY 2016–2018	Change in Number of Measures Reported FFY 2017–2018
	FFY 2016 (n = 28)	FFY 2017 (n = 30)	FFY 2018 (n = 33)		
Texas	17	22	27	10	5
Utah	14	13	15	1	2
Vermont	17	19	27	10	8
Virginia	16	16	15	-1	-1
Washington	15	21	23	8	2
West Virginia	23	25	25	2	0
Wisconsin	0	8	8	8	0
Wyoming	4	7	12	8	5

Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

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

The Adult Core Set varies slightly from year to year as follows:

The 2016 Adult Core Set, corresponding to reporting for FFY 2016, included 28 measures. Two measures were added to the 2016 Adult Core Set: Use of Opioids at High Dosage and Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

The 2017 Adult Core Set, corresponding to reporting for FFY 2017, included 30 measures. Three measures were added to the 2017 Adult Core Set: Contraceptive Care – Postpartum Women Ages 21-44, Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence, and Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%). One measure, Timely Transmission of Transition Record, was retired from the 2017 Adult Core Set.

The 2018 Adult Core Set, corresponding to reporting for FFY 2018, included 33 measures. Three measures were added to the 2018 Adult Core Set: Asthma Medication Ratio: Ages 19–64, Contraceptive Care – All Women Ages 21–44, and Concurrent Use of Opioids and Benzodiazepines.

Data from previous years may be updated based on new information received after publication of earlier reports.

Table 4. Number of States Reporting the Adult Core Set Measures, FFY 2016–2018

Measure	Number of States Reporting			Change in Number of States Reporting FFY 2016–2018	Change in Number of States Reporting FFY 2017–2018
	FFY 2016	FFY 2017	FFY 2018		
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older	37	43	43	6	0
Breast Cancer Screening	36	39	41	5	2
Cervical Cancer Screening	40	40	40	0	0
Chlamydia Screening in Women Ages 21–24	38	40	38	0	-2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	37	38	38	1	0
Prenatal and Postpartum Care: Postpartum Care	37	39	37	0	-2
Annual Monitoring for Patients on Persistent Medications	32	36	36	4	0
Adult Body Mass Index Assessment	33	32	35	2	3
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	27	32	34	7	2
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	30	32	33	3	1
Antidepressant Medication Management	33	34	33	0	-1
CAHPS Health Plan Survey 5.0H, Adult Version (Medicaid)	27	29	32	5	3
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	25	30	32	7	2
Follow-up After Emergency Department (ED) Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	n.a.	18	32	n.a.	14
Plan All-Cause Readmissions	23	25	30	7	5
Asthma Medication Ratio: Ages 19 to 64	n.a.	n.a.	29	n.a.	n.a.
Contraceptive Care: Postpartum Women Ages 21-44	n.a.	21	29	n.a.	8
Controlling High Blood Pressure	26	26	29	3	3
Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	24	27	28	4	1
PQI 01: Diabetes Short-Term Complications Admission Rate	26	29	28	2	-1
Use of Opioids at High Dosage in Persons Without Cancer	14	23	27	13	4
PQI 15: Asthma in Younger Adults Admission Rate	24	26	26	2	0
PQI 05: COPD or Asthma in Older Adults Admission Rate	24	25	25	1	0

Table 4. Number of States Reporting the Adult Core Set Measures, FFY 2016–2018 (continued)

Measure	Number of States Reporting			Change in Number of States Reporting FFY 2016–2018	Change in Number of States Reporting FFY 2017–2018
	FFY 2016	FFY 2017	FFY 2018		
PQI 08: Heart Failure Admission Rate	26	25	25	-1	0
Contraceptive Care: All Women Ages 21-44	n.a.	n.a.	24	n.a.	n.a.
Flu Vaccinations for Adults Ages 18 to 64	18	20	22	4	2
Medical Assistance with Smoking and Tobacco Use Cessation	18	20	20	2	0
Concurrent Use of Opioids and Benzodiazepines	n.a.	n.a.	15	n.a.	n.a.
PC-01: Elective Delivery	11	9	8	-3	-1
HIV Viral Load Suppression	5	5	6	21	1
Screening for Depression and Follow-Up Plan: Age 18 and Older	7	7	6	-1	-1
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)	n.a.	3	4	n.a.	1
PC-03: Antenatal Steroids	4	3	2	-2	-1
Timely Transmission of Transition Record	3	n.a.	n.a.	n.a.	n.a.

Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

Notes: The term “state” includes the 50 states and the District of Columbia.

The measures are sorted by the number of states reporting the measures for FFY 2018.

Data from previous years may be updated based on new information received after publication of earlier reports.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; n.a. = not applicable; measure was not reported in all three years.

Table 5. Performance Rates of Frequently Report Child Core Set Measures, FFY 2016–2018

Measure Name	Rate Definition	Number of States Reporting Using Core Set Specifications FFY 2016–2018	FFY 2016 Median	FFY 2017 Median	FFY 2018 Median
Primary Care Access and Preventive Care					
Children and Adolescents' Access to Primary Care Practitioners	Percentage with a PCP Visit in the Past Year: Ages 12 to 24 Months	44	95.5	95.4	95.7
Children and Adolescents' Access to Primary Care Practitioners	Percentage with a PCP Visit in the Past Year: Ages 25 Months to 6 Years	44	87.9	87.5	87.8
Children and Adolescents' Access to Primary Care Practitioners	Percentage with a PCP Visit in the Past Two Years: Ages 7 to 11 Years	44	91.1	91.1	91.2
Children and Adolescents' Access to Primary Care Practitioners	Percentage with a PCP Visit in the Past Two Years: Ages 12 to 19 Years	44	89.7	90.5	90.7
Well-Child Visits in the First 15 Months of Life	Percentage of Children who had 6 or More Well-Child Visits with a PCP during the First 15 Months of Life	45	61.4	59.8	63.5
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Percentage who had 1 or More Well-Child Visits with a PCP: Ages 3 to 6	46	68.4	68.3	69.8
Adolescent Well-Care Visit	Percentage with at Least 1 Well-Care Visit with a PCP or an OB/GYN Practitioner: Ages 12 to 21	45	45.1	44.7	49.4
Childhood Immunization Status	Percentage Up-to-Date on Immunizations (Combination 3) by their Second Birthday	37	69.1	68.7	68.4
Immunizations for Adolescents	Percentage Receiving Meningococcal Conjugate and Tdap Vaccines (Combination 1) by their 13th Birthday	39	71.9	74.5	77.4
Developmental Screening in the First Three Years of Life	Percentage of Children Screened for Risk of Developmental, Behavioral, and Social Delays Using a Standardized Screening Tool: Ages 0 to 3	22	36.0	38.1	43.3
Chlamydia Screening in Women Ages 16 to 20	Percentage of Sexually Active Women Screened for Chlamydia: Ages 16 to 20	42	49.2	49.8	50.2
Body Mass Index Assessment for Children and Adolescents	Percentage who had an Outpatient Visit with a PCP or OB/GYN Practitioner who had Body Mass Index Percentile Documented in the Medical Record: Ages 3 to 17	34	62.0	66.2	70.6

Table 5. Performance Rates of Frequently Report Child Core Set Measures, FFY 2016–2018 (continued)

Measure Name	Rate Definition	Number of States Reporting Using Core Set Specifications FFY 2016–2018	FFY 2016 Median	FFY 2017 Median	FFY 2018 Median
Maternal and Perinatal Health					
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Percentage of Women Delivering a Live Birth with a Prenatal Care Visit in the First Trimester or within 42 Days of Enrollment in Medicaid or CHIP	37	79.4	81.6	80.6
Care of Acute and Chronic Conditions					
Ambulatory Care: Emergency Department Visits	Emergency Department Visits per 1,000 Beneficiary Months: Ages 0 to 19 [Lower rates are better]	41	43.1	41.9	44.2
Behavioral Health Care					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Percentage on Two or More Concurrent Antipsychotic Medications: Ages 1 to 17 [Lower rates are better]	28	2.8	2.6	2.9
Follow-Up Care for Children Newly Prescribed ADHD Medication	Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase: Ages 6 to 12	36	49.7	50.2	48.7
Follow-Up Care for Children Newly Prescribed ADHD Medication	Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits in the 9 Months Following the Initiation Phase: Ages 6 to 12	36	61.3	61.7	61.1
Dental and Oral Health Services					
Percentage of Eligibles Who Received Preventive Dental Services	Percentage with at Least 1 Preventive Dental Service: Ages 1 to 20	49	47.9	48.3	48.0
Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk	Percentage at Elevated Risk of Dental Caries (Moderate or High Risk) who Received a Sealant on a Permanent First Molar Tooth: Ages 6 to 9	27	22.9	22.3	24.1

Sources: Mathematica analysis of FFY 2016–2018 MACPro reports and Form CMS-416 reports.

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

This table includes measures that were reported by 20 or more states using Child Core Set specifications for all three years (FFY 2016–2018). When a state reported separate rates for its Medicaid and CHIP populations, the median rates were calculated using the rate for the larger measure-eligible population. The results for each measure reflect only the states that reported on the measure for all three years. Data from previous years may be updated based on new information received after publication of earlier reports.

Measure-specific tables are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

Table 6. Performance Rates of Frequently Report Adult Core Set Measures, FFY 2016–2018

Measure Name	Rate Definition	Number of States Reporting Using Core Set Specifications FFY 2016–2018	FFY 2016 Median	FFY 2017 Median	FFY 2018 Median
Primary Care Access and Preventive Care					
Cervical Cancer Screening	Percentage of Women Screened for Cervical Cancer: Ages 21 to 64	38	52.8	55.0	55.2
Chlamydia Screening in Women Ages 21 to 24	Percentage of Sexually Active Women Screened for Chlamydia	36	59.3	61.1	60.8
Adult Body Mass Index Assessment	Percentage who had an Outpatient Visit with a BMI Documented in the Medical Record: Ages 18 to 64	29	79.9	78.6	83.0
Maternal and Perinatal Health					
Prenatal and Postpartum Care: Postpartum Care	Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 21 and 56 Days after Delivery	31	55.2	60.1	62.7
Care of Acute and Chronic Conditions					
Comprehensive Diabetes Care: Hemoglobin A1c Testing	Percentage with Diabetes (Type 1 or Type 2) who had a Hemoglobin A1c (HbA1c) Test: Ages 18 to 64	35	83.3	84.9	85.2
PQI 01: Diabetes Short-Term Complications Admission Rate	Inpatient Hospital Admissions for Diabetes Short-Term Complications per 100,000 Beneficiary Months: Ages 18 to 64 [Lower rates are better]	22	18.3	18.5	17.4
PQI 08: Heart Failure Admission Rate	Inpatient Hospital Admissions for Heart Failure per 100,000 Beneficiary Months: Ages 18 to 64 [Lower rates are better]	22	20.9	22.8	24.4
Controlling High Blood Pressure	Percentage who had a Diagnosis of Hypertension and whose Blood Pressure was Adequately Controlled during the Measurement Year: Ages 18 to 64	22	54.9	59.2	59.6

Table 6. Performance Rates of Frequently Report Adult Core Set Measures, FFY 2016–2018 (continued)

Measure Name	Rate Definition	Number of States Reporting Using Core Set Specifications FFY 2016–2018	FFY 2016 Median	FFY 2017 Median	FFY 2018 Median
Behavioral Health Care					
Antidepressant Medication Management:	Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 12 Weeks: Ages 18 to 64	30	51.8	49.1	50.0
Antidepressant Medication Management:	Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 6 Months: Ages 18 to 64	30	37.2	34.5	34.7
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Percentage with Schizophrenia who were Dispensed and Remained on Antipsychotic Medication for at Least 80 Percent of their Treatment Period: Ages 19 to 64	27	60.0	62.0	58.0
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Percentage with Schizophrenia or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test: Ages 18 to 64	23	78.6	78.8	79.6

Source: Mathematica analysis of FFY 2016–2018 MACPro reports.

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

This table includes measures reported by 20 or more states using Adult Core Set specifications for all three years (FFY 2016–FFY 2018). The results for each measure reflect only the states that reported on the measure for all three years.

Data from previous years may be updated based on new information received after publication of earlier reports.

Measure-specific tables are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Primary Care Access and Preventive Care Measures		39	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	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Emergency Department (ED) Visits Measures																																												
ED Visits for Dental Caries in Children		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-
ED Visits per 1,000 MM	CS/H	18	X	X	X	-	-	X	X	X	-	X	-	-	-	X	-	-	X	-	-	-	-	X	X	X	X	-	X	-	X	X	X	-	-	-	-	-	-	-	X	-	-
ED Utilization		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ED Visits		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ER Utilization by MLTSS Members		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Immunization Measures																																											
Childhood Immunization Status	CS/H	29	-	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	X	X	X	-	X	-
Flu Vaccinations for Adults	CS/H	6	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	X	-	-	-	-	-	X	-	-	-	X	-	-	X	-	-	-	X	-	-
Human Papillomavirus (HPV) Vaccine for Female Adolescents	C	4	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-
Immunizations for Adolescents	CS/H	22	-	X	X	X	-	X	X	X	-	X	-	X	-	-	-	X	X	-	-	X	-	X	X	X	X	-	X	-	X	-	X	-	X	-	X	X	-	X	-	-	-
Pneumococcal Vaccination Status for Older Adults	H	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-
Primary Care Access Measures																																											
Adolescent Preventive Care		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-
Adolescent Preventive Screening/Counseling		1	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services	H	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	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Adults' Access to Primary Care Physicians		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ambulatory Care - Outpatient Visits and ED Visits	H	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	X
Children and Adolescents' Access to Primary Care Physicians	CS/H	27	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	-	X	X	-	-	-
Assessments and Care Plans After Enrollment for Dual Eligibles		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Preventive Health Checkups and Screenings for Children		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-
Individuals with Special Health Care Needs (ISHCN) Access to Preventive Care		1	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Members With Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) Receiving Preventive Healthcare Visits		1	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Outpatient Visits per 1,000 MM	H	11	-	X	X	-	-	X	X	X	-	X	-	-	-	X	-	-	X	-	-	-	-	-	-	-	X	-	X	-	-	-	X	-	-	-	-	-	-	-	-	-	-
Screening Measures																																											
Breast Cancer Screening	CS/H	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	-	-	-
Cervical Cancer Screening	CS/H	26	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	X	-	-	-
Chlamydia Screening	CS/H	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
Cholesterol Screening for Adults		1	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Colorectal Cancer Screening	H	4	-	X	-	-	-	-	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-
Developmental Screening in the First Three Years of Life	CS	8	X	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	X	-	-	-	-	X	X	-	-	-	X	-	-	-	-	-	X

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screening		1	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lead Screening in Children	H	12	-	-	-	X	-	X	X	-	-	-	-	-	X	-	-	X	X	-	-	X	-	-	X	-	X	-	-	X	-	-	X	-	X	-	-	-	-	-	-	-	-
Non-Recommended Cervical Cancer Screening in Adolescent Female: Ages 16 - 20	H	8	-	-	X	X	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	-	X	-	-	-	-	-	-	-	-
Weight Assessment/Body Mass Index (BMI) Measures																																											
Adult BMI Assessment	CS/H	21	-	-	X	X	-	X	X	-	-	X	-	-	X	X	-	X	X	X	-	X	-	X	X	-	X	-	-	X	X	-	X	-	X	-	X	-	X	-	-	-	-
Counseling for Nutrition and Physical Activity		1	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Height and Weight Documented and Appropriate Weight for Height for Adults		1	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Height and Weight Documented and Appropriate Weight for Height for Children and Adolescents		1	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Assessment for Children/Adolescents	CS/H	22	-	-	X	X	-	X	X	X	-	X	-	-	X	X	-	X	X	-	-	X	-	-	X	X	X	-	X	X	X	-	X	-	X	-	X	X	-	X	-	-	-
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	H	10	-	X	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X	X	-	-	-	X	-	X	-	X	-	-	-	-	X	-	-
Weight Assessment and Counseling for Nutrition and	H	10	-	X	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X	X	-	-	X	X	-	X	-	X	-	-	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Physical Activity for Children/Adolescents – Counseling for Physical Activity																																												
Well-Child Visit Measures																																													
Adolescent Well-Care Visits	CS/H	28	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	-	X	X	-	X	-
Well-Child Visits in the First 15 Months of Life	CS/H	28	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	X	X	X	X	-	-	-
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	CS/H	32	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	X	X	-	X	X	X	X	X	-	X	-
Maternal and Perinatal Health Measures		31	-	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	X	-	X	X	X	X	-	X	-
Maternal and Perinatal Health																																												
Cesarean Section (PC-02)	CS	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-
Contraceptive Care – Postpartum Women		3	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-
Contraceptive Care – Most and Moderately Effective Methods, All Women: Ages 15 – 44	CS	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	X	-	-	-	X	-	-	-	-	-	-	-
Elective Delivery (PC-01)	CS	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-
Frequency of Ongoing Prenatal Care	CH	6	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	X	-	-	-	-	-	X	-	-	-	-	X	X	X	-	-	-	-	-	-	-	-	-
Live Births Weighing Less Than 2,500 Grams	CS	3	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-
Low Birth Weight Rate (PQI-09)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-
Maternity Risk Factor Assessment		2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-
Prenatal and Postpartum Care	CS/H	29	-	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	X	X	X	-	X	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Care of Acute and Chronic Conditions Measures		37	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	X	X	X	-	X	X	X	-	X	X	X	X	-	X	X
Asthma and Chronic Obstructive Pulmonary Disease (COPD) Measures																																											
Asthma Admission Rate (PDI-14)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Asthma in Younger Adults Admission Rate (PQI-15)	CS	5	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	X	-	-
Asthma Medication Ratio	CS/H	15	-	X	-	X	-	-	X	-	-	-	-	-	-	X	-	X	X	-	-	X	-	X	-	X	X	-	-	X	-	-	X	-	X	-	X	-	X	-	-	-	X
Asthma Patients with One or More Asthma-Related ED Visits		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-
COPD or Asthma in Older Adults Admission Rate (PQI-05)	CS	5	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	X	-	-
Medication Management for People with Asthma	H	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	-	-	-
Pharmacotherapy Management of COPD Exacerbation	H	13	-	-	X	X	-	-	X	-	-	-	-	-	-	-	X	-	-	-	X	-	-	X	X	-	-	-	X	X	-	X	-	X	-	X	-	X	-	-	-	-
Use of Appropriate Medications for People with Asthma		1	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	H	10	-	-	X	X	-	-	X	-	-	-	-	-	-	-	X	-	-	-	X	-	-	X	-	-	-	-	X	-	-	X	-	X	-	X	-	X	-	-	-	-	-
Cardiac Care Measures																																											
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	H	8	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X	-	-	-	X	-	X	-	-	-	-	-	-	-	-	X	-	X	-	X	-	-	-	-	-	-	-
Controlling High Blood Pressure	CS/H	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	-	-	-
Heart Failure Admissions (PQI-08)	CS	5	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	X	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Persistence of Beta Blocker Treatment After a Heart Attack	H	8	-	-	X	X	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-	X	-	-	X	-	X	-	-	-	-	-	-	-	-
Statin Therapy for Patients with Cardiovascular Disease	H	7	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-	-	X	-	X	-	X	-	X	-	-	-	-	-	-
Statin Therapy for Patients with Cardiovascular Disease-Received Statin Therapy: Males Ages 21-75	H	5	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	X	-	X	-	-	-	-	-	-	-	-
Statin Therapy for Patients with Cardiovascular Disease, Received Statin Therapy: Females Ages 40 - 75	H	5	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	X	-	X	-	-	-	-	-	-	-	-
Statin Therapy for Patients with Cardiovascular Disease- Statin Adherence 80%: Males Ages 21-75	H	5	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	X	-	X	-	-	-	-	-	-	-	-
Statin Therapy for Patients with Cardiovascular Disease- Statin Adherence 80%: Females Ages 40-75	H	5	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	X	-	X	-	-	-	-	-	-	-	-
Statin Therapy for Patients with Diabetes	H	9	-	-	X	X	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-	-	X-	-	X	-	X	-	-	-	-	-	-	-	-
Statin Therapy for Patients with Diabetes- Received Statin Therapy: Ages 40 – 75	H	9	-	-	X	X	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-	-	-X	-	X-	-	X-	-	-	-	-	-	-	-	-
Diabetes Care Measures																																												
Comprehensive Diabetes Care	CS/H	31	-	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	X	-	X	X	X	X	-	X	-
Comprehensive Diabetes Care-Lipid Screening		1	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Diabetes Care for People with Serious Mental Illness	CS/H	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Diabetes Monitoring for People with Diabetes and Schizophrenia	H	11	-	-	-	X	-	-	X	-	-	-	X	-	-	-	-	X	X	-	-	X	-	X	-	X	-	-	-	X	-	-	X	-	X	-	-	-	-	-	-	-	-
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	CS/H	11	-	-	-	X	-	X	X	X	-	-	-	-	-	-	-	-	X	-	-	X	-	X	-	-	-	-	X	X	-	-	X	-	X	-	-	-	-	-	-	-	-
Diabetes Short-Term Complications Admissions (PDI-15)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Diabetes Short-Term Complications Admissions (PQI-01)	CS	6	X	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	X	-
Diabetes with Long-Term Complications Admissions (PQI-03)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Lower-Extremity Amputation Among Patients With Diabetes (PQI-16)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Prevention Quality Indicator 93 (PQI-93)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Uncontrolled Diabetes Admissions (PQI-14)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
HIV Care Measures																																											
HIV Viral Load Suppression	CS	3	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Hospital Use Measures																																											
Mental Health Utilization-Average Length of Stay		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Plan All-Cause Readmissions	CS/H	10	X	X	-	-	-	X	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-	X	-	X	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Medication Management Measures																																												
Annual Monitoring for Patients on Persistent Medications	CS/H	22	X	X	X	X	X	X	X	X	X	X	-	-	-	-	X	X	X	-	-	X	-	X	X	X	X	-	-	X	-	-	X	-	X	-	X	-	-	-	-	-	-	-
Antibiotics Utilization	H	6	-	-	X	-	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	X	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	H	12	-	X	X	X	-	-	X	-	-	-	-	-	-	-	-	X	X	-	-	X	-	-	-	-	-	-	-	X	-	-	X	-	X	-	X	-	-	X	-	-	-
Medication Reconciliation Post-Discharge	H	3	-	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-
Use of High-Risk Medications in the Elderly	H	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-
Other Acute and Chronic Conditions Measures																																											
Community-Acquired Pneumonia Admissions (PQI-11)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	H	8	-	-	X	X	-	-	X	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-	X	-	-	X	-	X	-	-	-	-	-	-	-	-
Frequency of Selected Procedures	H	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-
Gastroenteritis Admissions (PDI-16)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-
Hypertension Admissions (PQI-07)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-
Inpatient Utilization-General Hospital/Acute Care	H	8	X	-	X	-	-	-	X	X	-	-	-	-	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-
Pediatric Quality Overall Composite (PDI-90)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Pediatric Quality Acute Composite (PDI-91)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Pediatric Quality Chronic Composite (PDI-92)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Perforated Appendix Admissions (PDI-17)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Perforated Appendix Admissions (PQI-02)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Prevention Quality Overall Composite (PQI-90)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Prevention Quality Acute Composite (PQI-91)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Prevention Quality Chronic Composite (PQI-92)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Standardized Healthcare-Associated Infection Ratio	H	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
Urinary Tract Infection Admissions (UTI) (PDI-18)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Urinary Tract Infection Admission Rate (UTI) (PQI-12)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Use of Imaging Studies for Low-Back Pain	H	13	-	X	X	X	-	-	X	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	X	X	-	-	-	X	-	-	X	-	X	-	-	X	-	X	-	-	-
Pharyngitis Measures																																												
Appropriate Testing for Children with Pharyngitis	CH	13	-	-	X	X	-	-	X	-	-	-	-	-	-	-	-	X	X	-	-	X	-	-	-X	X	X	-	-	-X	-	-	-X	-	X	-	X	-	-	-	-	-	-
Upper Respiratory Infection (URI) Measures																																												
Appropriate Treatment for Children with URI	H	14	-	-	X	X	-	-	X	-	-	-	-	-	-	-	-	X	X	-	-	X	-	-	X	X	-	-	-	X	-	-	X	-	X	-	X	X	-	X	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Behavioral Health Care Measures		36	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	X	X	X	X	X	X	X	X	X	X	X	X
Attention-Deficit/Hyperactivity Disorder (ADHD) Measures																																												
Follow-Up for Care for Children Prescribed ADHD Medication	CS/H	21	-	-	X	X	-	X	X	X	-	-	-	-	-	X	-	-	X	-	-	X	-	X	X	X	X	-	X	X	X	-	X	-	X	-	X	-	X	X	-	-	X
Other Behavioral Health Measures																																												
Access to Behavioral Health Care		5	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-
Behavioral Health Access Monitoring		3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	X	-	-	-	-
Behavioral Health Risk Assessment for Pregnant Women	C	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	X	-
Follow-Up After ED Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence-7 day	CS/H	3	-	-	-	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-
Follow-Up After ED Visit for Mental Illness or Alcohol and Other Drug Dependence-30-day	CS/H	4	-	-	-	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	X	-	-	-	-	-	-
Receipt of Behavioral Health Services		1	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Behavioral Health Measures	CS	10	-	-	-	X	-	X	X	-	-	-	-	-	-	-	X	X	-	-	-	-	-	-	-	X	-	X	-	-	-	X	-	-	X	X	-	-	-	-	-	-	-
Mental Health Measures																																												
Adherence to Antipsychotics for Individuals with Schizophrenia	CS/H	12	-	-	-	X	-	X	X	-	-	-	-	-	-	-	X	-	-	X	-	X	-	X	-	-	X	X	-	-	X	-	X	-	X	-	X	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Antidepressant Medication Management	CS/H	19	-	-	-	X	-	X	X	X	-	-	-	-	-	X	X	-	X	-	-	X	-	X	X	X	-	X	-	X	X	-	-	-	X	-	X	X	X	X	-	-	-
Follow-Up After ED Visit for Mental Illness	H	14	-	-	-	X	-	X	X	X	-	X	-	-	-	-	X	-	-	-	-	-	-	-	-	-	X	-	X	X	-	-	X	X	X	-	X	-	X	-	-	-	-
Follow-Up After Hospitalization for Mental Illness	CS/H	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
Mental Health Engagement		1	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mental Health Penetration Rate		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mental Health Utilization[a]	H	9	-	-	X	-	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	X	-	X	-	-	-	X	-	-	-	-	X	-
Mental Health Utilization-Inpatient Discharges		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Metabolic Monitoring for Children and Adolescents on Antipsychotics	H	11	-	-	X	X	-	X	X	-	-	X	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	X	-	-	-	X	-	X	-	X	-	-	-	-	-	-
Readmission Rates for Mental Health		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Readmission Within 30-Days of Inpatient Psychiatric Discharge		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	CS/H	9	-	-	-	X	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	X	-	X	-	X	-	X	-	-	-	-	-	-
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	CS/H	12	-	-	X	X	-	X	X	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	X	-	X	-	X	-	X	-	X	-	X	-	-	-	-	-	-	-
Substance Use Disorder Measures																																												
Concurrent Use of Opioids and Benzodiazepines	CS	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Follow-Up After ED Visit for Alcohol or Other Drug Dependence	H	4	-	-	-	X	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-
Identification of Alcohol and Drug Services	H	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	CS/H	16	-	-	-	-	-	X	X	X	-	X	-	-	-	-	-	-	-	-	-	X	X	X	-	X	-	-	X	-	X	-	X	-	X	-	X	X	-	X	-	X	-
Medical Assistance with Smoking and Tobacco Use Cessation	CS/H	9	-	-	-	X	-	X	-	-	-	-	-	-	-	-	-	X	X	-	-	-	-	X	-	-	-	-	X	-	-	-	-	-	-	-	X	-	X	-	-	X	-
Readmission Rates for Substance Abuse		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Substance Abuse Penetration Rate		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tobacco Cessation - Counseling		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-
Tobacco Screening for Adults		1	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dental and Oral Health Services Measures		20	X	-	-	X	-	X	X	-	-	-	X	X	-	-	-	X	-	X	-	X	-	-	X	X	-	X	X	X	X	-	-	X	X	-	-	X	X	-
Annual Dental Visits	H	18	X	-	-	X	-	X	X	-	-	-	X	X	-	-	-	X	-	X	-	-	-	-	X	X	-	X	X	-	X	X	-	-	X	X	-	-	X	X	-
Dental Sealants for 6-9 Year-Olds	CS	4	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	X	-	-	-	-	-	-	-	-	X	-
Follow-Up after ED Visits for Dental Caries in Children[b]		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Continuity of Care in Dental Practice/Clinic[b]		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Received Dental Treatment Service[b]		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Received Comprehensive or Periodic Oral Evaluation[b]		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Received Dental Service Within the Past Year[b]		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Percentage of Eligibles Who Received Dental Treatment Services		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Percentage of Eligibles Who Received Preventive Dental Services	CS	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	X	-
Preventive Dental Visit		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Experience of Care Measures		27	-	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	-	X	X	-	X	-
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	CS/H	27	-	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	X	-	X	-
Diversity of Membership[c]	H	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Face-to-face Encounters	H	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Member Services and Satisfaction[d]	H	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-
Total Membership	H	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Other Measures		10	-	-	-	-	X	X	-	-	-	-	-	-	X	X	X	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	X	-	-	X	-	X	-	-	-	-
Administrative Measures																																											
3M Health Information Systems Measures: Potentially Preventable Events (PPEs)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-
Access/Availability of Care		1	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Board Certification	H	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	-	-	-
Care of Older Adults	H	3	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-
Enrollment by State and Product Line	H	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-

Table 7. Performance Measures Included in External Quality Review (EQR) Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain (continued)

Measure Name	Core Set/ HEDIS measure	Number of states reporting measure	AZ	CA	CO	DC	DE	FL	GA	HI	IA	IL	IN	KS	KY	LA	MA	MD	MI	MN	MO	MS	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OR	PA	RI	SC	TN	TX	UT	VA	WA	WI	WV	WY
Frequency of Selected Procedures (FSP)		1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-
Other Administrative Measures		2	-	-	-	-	X[e]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X[f]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Care Coordination Measures																																											
Other Care Coordination Measures		1	-	-	-	-	-	-	-	-	-	-	-	-	-	X[g]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Source: EQR technical reports submitted to CMS for the 2018–2019 reporting cycle as of May 31, 2019.

Notes: During the 2018–2019 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ME, MT, OK, and VI. WY is CHIP-only. In addition, ID and PR did not submit an EQR technical report before May 31, 2019 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. WY is CHIP only.

Information about the EQR process is available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

An “X” indicates that the state reported this measure; a dash (-) indicates that the state did not report the measure.

A “CS” denotes the measure was included in the Adult and/or Child Core Set; an "H" denotes a HEDIS measure. Core Set measures may vary from year to year.

ADHD = Attention Deficit Hyperactivity Disorder; 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; EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; EQR = External Quality Review; ER = Emergency Room; FSP = Frequency of Selected Procedure; HEDIS = Healthcare Effectiveness Data and Information Set; HIV = Human Immunodeficiency Virus; HPV = Human Papillomavirus; MCO = Managed Care Organization; MM = Member Months; MLTSS = Managed Long-Term Services and Supports; PC = Prenatal Care; PDI = Pediatric Quality Indicator; PIHP = Prepaid Inpatient Health Plan; PQI = Prevention Quality Indicator; SED = Serious Emotional Disturbance; SMI = Serious Mental Illness; PPE = Potentially Preventable Events; URI = Upper Respiratory Infection; UTI = Urinary Tract Infection.

[a] Unspecified utilization of mental health services, which can take place in any setting, such as inpatient, intensive outpatient or partial hospitalization, outpatient, or ED.

[b] Dental Quality Alliance (DQA) measures. DQA was established by the American Dental Association to develop performance measures for oral health care.

[c] Includes race/ethnicity and language diversity.

[d] Includes call abandonment, transportation availability, transportation timeliness, disenrollment rate, voluntary disenrollment rate, retention rate, ID cards sent within 10 days of [n]otification of enrollment, member handbook.

[e] Health Reimbursement Arrangement (HRA) completed.

[f] Medicaid Long Term Services and Supports (MLTSS) Used by Home and Community Based Services Members.

[g] Beneficiaries participated in plan of care (POC) development; participants whose POC met HCBS requirements; participants with POCs reflecting supports and services necessary to address goals; and participants with POCs updated timely.

Table 8. Performance Measure Topics for the 2018-2019 Reporting Cycle

Measure topic and subtopics	Number of states reporting
Primary Care Access and Preventive Care	**39**
Primary care access	34
Screening	33
Immunizations	32
Well-child visits	32
Weight assessment/Body mass index	24
Emergency department (ED) visits[a]	23
Care of Acute and Chronic Conditions	**37**
Diabetes care	33
Asthma and chronic obstructive pulmonary disease (COPD)[b]	30
Cardiac care	28
Medication management	24
Upper respiratory infection (URI)	14
Pharyngitis	13
Hospital use for chronic conditions	11
HIV care	3
Behavioral Health Care[c]	**36**
Mental health	29
Attention deficit/hyperactivity disorder (ADHD)	22
Substance use disorder	19
Maternal and Perinatal Health	**31**
Prenatal and postpartum care	29
Frequency of ongoing prenatal care	6
Contraceptive care—most and moderately effective methods	6
Experience of Care	**27**
Consumer Assessment of Health Providers and Systems (CAHPS) surveys	27
Diversity of membership	2
Member services and satisfaction	1
Dental and Oral Health Services	**20**
Annual dental visits	20
Dental sealants for children	18
Children that received preventive dental services	4

Source: EQR technical reports submitted to CMS for the 2018–2019 reporting cycle as of May 31, 2019.

[a] Measures under this topic are indicators of access to primary care, such as ED visits for dental caries in children and ED utilization. For more detail, please see Table 7, Performance Measures Included in EQR Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain.

Table 8. Performance Measure Topics for the 2018-2019 Reporting Cycle (continued)

[b] Other acute and chronic conditions measures reported by 18 states included use of imaging studies for low-back pain, disease modifying anti-rheumatic drug therapy for rheumatoid arthritis, and frequency of selected procedures for acute or chronic conditions. For more detail, please see Table 7, Performance Measures Included in EQR Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain.

[c] Fifteen states reported other behavioral health measures, including follow-up after ED visits for mental illness or other alcohol and other drug dependence, behavioral health risk assessment for pregnant women, and access to behavioral health services. For more detail, please see Table 7, Performance Measures Included in EQR Technical Reports, 2018-2019 Reporting Cycle, by State and Core Set Domain.

Table 9. Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, by Core Set Domain, 2018–2019 Reporting Cycle

State	Year(s) of Data	PIP Population	Total Unduplicated Number of PIPs	Primary Care Access and Preventive Care	Maternal and Perinatal Health	Care of Acute and Chronic Conditions	Behavioral Health Care	Dental and Oral Health Services	Experience of Care	Other
Total PIPs	**2016-2019**		**858**	**186**	**112**	**249**	**240**	**54**	**38**	**110**
Total States			**41**	**28**	**17**	**33**	**31**	**16**	**9**	**18**
Arizona	2016	A	4	-	-	-	-	-	-	4
		A/C	11	-	-	-	-	-	-	11
		C	2	-	-	-	-	-	-	2
California	2017-2019	A	46	10	-	28	1	-	-	5
		A/C	19	-	14	3	-	-	2	-
		C	11	9	-	2	-	-	-	-
		U	4	-	-	-	-	-	1	3
Colorado	2017	A	3	-	-	3	2	-	-	-
		C	9	1	-	9	5	-	-	1
Delaware	2018	A	2	1	-	1	-	1	-	-
		C	1	-	-	1	-	-	-	-
District of Columbia	2017	A	6	-	-	6	3	-	-	-
		A/C	3	-	3	-	-	-	-	-
		C	3	-	-	3	-	-	-	-
Florida	2018	A	28	-	-	12	2	-	6	11
		A/C	22	11	11	5	2	-	4	1
		C	19	2	-	2	1	14	1	-
		U	7	-	-	1	1	-	4	1
Georgia	2018	A	2	-	-	1	1	-	-	-
		A/C	8	-	1	-	2	-	-	5
Hawaii	2017	A	1	-	-	-	1	-	-	-
		A/C	9	-	4	1	3	-	1	-
		C	1	-	-	-	-	-	1	-
		U	1	-	-	-	-	-	1	-
Illinois	2018	A/C	14	-	-	14	7	-	-	-
Indiana	2017	U	1	-	-	-	-	-	-	1
		A	4	-	-	1	1	-	-	2
		A/C	7	-	1	1	2	-	-	3
		C	1	-	-	-	-	1	-	-
Iowa	2017	C	3	3	-	-	-	-	-	-
		U	3	-	-	-	-	-	3	-
Kansas	2017-2018	A	2	-	-	2	2	-	-	-

Table 9. Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, by Core Set Domain, 2018–2019 Reporting Cycle (continued)

State	Year(s) of Data	PIP Population	Total Unduplicated Number of PIPs	Primary Care Access and Preventive Care	Maternal and Perinatal Health	Care of Acute and Chronic Conditions	Behavioral Health Care	Dental and Oral Health Services	Experience of Care	Other
		C	4	4	-	-	-	-	-	-
Kentucky	2017	A	7	5	-	5	5	-	-	-
		A/C	7	-	6	-	7	-	-	-
		C	7	4	-	-	1	3	-	-
Louisiana	2017-2018	A/C	5	-	5	-	-	-	-	-
		C	5	-	-	-	5	-	-	-
Maryland	2017	A/C	8	-	-	8	-	-	-	-
		C	8	8	-	-	-	-	-	-
Massachusetts	2017-2018	A	23	1	-	9	13	1	-	1
		A/C	6	-	5	-	1	-	-	-
		U	1	-	-	1	-	-	-	-
Michigan	2018	A/C	11	-	11	-	-	-	-	-
Minnesota	2018	A	7	-	-	-	7	-	-	6
Mississippi	2016-2018	A	3	-	-	2	-	-	-	1
		A/C	1	1	-	-	-	-	-	-
		C	9	4	-	2	2	-	-	1
		U	3	1	-	2	-	-	-	-
Missouri	2017	C	4	2	-	-	-	2	-	-
Nebraska	2018	A	1	1	1	-	-	-	-	-
		A/C	10	2	5	3	3	2	-	-
Nevada	2018	A/C	6	-	-	6	6	-	-	-
New Hampshire	2017	A	2	-	-	2	1	-	-	-
		A/C	2	1	-	1	-	-	-	-
		C	2	2	-	-	-	-	-	-
New Jersey	2018	A	6	-	-	1	-	-	-	5
		A/C	4	-	4	-	-	-	-	-
		C	4	4	-	-	-	-	-	-
New Mexico	2016	A	12	-	-	6	4	-	-	3
		C	4	1	-	-	-	3	-	-
New York	2017	A	2	-	-	1	1	-	-	-
		A/C	16	-	15	-	14	-	-	-
North Carolina	2018	A/C	26	4	-	9	24	-	1	4
		C	1	-	-	-	1	-	-	-
North Dakota	2017	A/C	2	-	-	1	1	-	-	-
		C	3	2	-	-	-	1	-	-
Ohio	2018	A	5	-	-	5	-	-	-	-

Table 9. Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, by Core Set Domain, 2018–2019 Reporting Cycle (continued)

State	Year(s) of Data	PIP Population	Total Unduplicated Number of PIPs	Primary Care Access and Preventive Care	Maternal and Perinatal Health	Care of Acute and Chronic Conditions	Behavioral Health Care	Dental and Oral Health Services	Experience of Care	Other
Oregon	2018	A	7	5	-	-	1	-	-	1
		A/C	40	-	12	8	18	4	-	1
		C	6	4	-	-	1	-	-	1
		U	8	-	-	2	3	-	-	3
Pennsylvania	2017-2018	A	6	-	-	6	-	-	-	-
		A/C	5	-	-	5	5	-	-	-
		C	29	20	-	-	-	9	-	-
		U	9	-	-	9	-	-	-	-
Rhode Island	2017-2018	A	5	-	-	1	4	-	-	-
		C	6	4	-	-	-	2	-	-
South Carolina	2017-2018	A	2	-	-	1	-	-	-	1
		A/C	8	2	1	2	1	-	1	1
		C	2	2	-	-	-	-	-	-
		U	1	-	-	1	-	-	-	-
Tennessee	2018	A	19	1	-	-	12	-	3	3
		A/C	26	2	9	-	2	1	7	8
		C	16	14	-	-	1	1	-	-
Texas	2018	A	6	-	-	6	5	-	-	-
		A/C	13	1	-	13	1	-	-	-
		C	20	2	-	16	-	4	-	-
Utah	2018	A	2	1	-	1	-	-	-	-
		A/C	11	-	-	-	11	-	-	-
		C	5	4	-	1	-	-	-	-
Virginia	2018	A	6	-	-	6	-	-	-	-
Washington	2017	A	6	1	-	-	5	-	-	-
		A/C	3	-	-	-	2	-	1	-
		C	34	26	-	2	5	-	-	2
		U	13	-	-	1	8	-	-	4
West Virginia	2017	A	2	-	-	-	1	-	-	1
		A/C	4	-	4	-	4	-	-	-
		C	6	2	-	-	-	4	-	-
Wisconsin	2018	U	2	-	-	-	-	-	-	2
		A	19	1	-	6	3	-	1	10
		A/C	16	2	-	1	13	-	-	-
		C	8	6	-	-	2	-	-	1
Wyoming	2018	C	3	2	-	1	-	1	-	-

Source: EQR technical reports submitted to CMS for the 2018–2019 reporting cycle as of May 31, 2019.

Table 9. Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, by Core Set Domain, 2018–2019 Reporting Cycle (continued)

Notes: During the 2018–2019 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AK, AL, AR, CT, GU, ME, MT, OK, and VI. In addition, ID and PR did not submit an EQR technical report before May 31, 2019 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. WY is CHIP only.

Information about the EQR process is available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

PIPs can focus on more than one domain, thus the PIPs listed in this table are not mutually exclusive. A PIP is counted in a column if it pertains to the domain area listed. An unduplicated count of PIPs within this table is provided.

An “A” denotes that the PIP focused on an adult population; an “A/C” denotes that the PIP focused on both an adult and child population; a “C” denotes that the PIP focused on a child population; a “U” denotes that the PIP’s population could not be determined and is therefore unspecified.

CHIP = Children’s Health Insurance Program; EQR = External Quality Review; MCO = Managed Care Organization; PIHP = Prepaid Inpatient Health Plan; PIP= Performance Improvement Project.