

The “Nuts and Bolts” Behind Quality Measurement in Medicaid Managed Care

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INTRODUCTION

Content Highlight

This paper examines the state of quality measurement at this critical juncture for state Medicaid programs, especially as it relates to comprehensive risk-based managed care, and makes several recommendations to improve quality measures.

Policymakers are implementing far-reaching transformations of Medicaid in almost every state, ranging from expansions of managed care to delivery system reforms, and quality measurement is essential for judging the success of these efforts. Stakeholders may rely on quality measurement to determine the extent to which changes are implemented as intended, if the changes improve health care services delivery and health outcomes, and where gaps suggest the need for additional efforts. Further, quality measurement can be used to identify any unintended consequences on access or health.

In 2015 alone, 27 states introduced or expanded delivery system transformations including patient-centered medical homes, accountable care organizations, and health homes.¹ States are also shifting toward, or expanding access to, comprehensive, risk-based Medicaid managed care and requiring plans to achieve goals for access, quality,

and cost. In 2015, states spent three times as much of their Medicaid budget through managed care plans as they did in 2006. Of the roughly \$525 billion in total Medicaid expenditures for 2015, managed care spending was nearly \$240 billion.²

Managed care expansions and delivery system transformations are the most recent motivators for more quality measurement, but are not the only ones. Prior to that, payers, providers, and consumers alike—both in the private and public sectors—sought better information on the quality of care delivered or paid for. Payers, including health plans, employers, and federal and state governments, want to monitor the extent to which they are investing in high quality, cost effective services that improve the health of individuals. Increasingly, payments are linked to outcomes, and quality measurement is an essential tool for calculating those financial rewards. Health care providers need quality measures to assess whether patients are faring better as a result of changes at the front-line of care, including both payer-instigated changes and professionally driven advancements. Patients, too, are consumers of quality information. Increasingly, they are encouraged to use quality information and comparison tools when selecting a health plan or provider.

This paper examines the state of quality measurement at this critical juncture for state Medicaid programs, especially as it relates to comprehensive risk-based managed care, and makes several recommendations to improve quality measures. The ongoing need for quality measurement, paired with recent changes in service delivery and payment, make it clear that the field of measurement will need to grow significantly in the next several years.



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THE SHIFT IN MEDICAID MANAGED CARE DEMOGRAPHICS

Quality measurement and reporting in state Medicaid programs has become increasingly important as more Medicaid beneficiaries, including more diverse populations, have moved into managed care plans. Managed care enrollment doubled between 2006 and 2015, largely due to changes in Medicaid managed care eligibility.³ States first enrolled individuals receiving Temporary Assistance to Needy Families (TANF), primarily mothers and children, in Medicaid managed care. Their health expenditures, on average, are much less than those for individuals with disabilities or individuals over age 65.⁴

More recently, Medicaid agencies have begun shifting individuals with more complex health needs into Medicaid managed care plans, recognizing that managed care organizations (MCOs) provide a higher level of care management and service integration while offering budget predictability for the state. Populations newly enrolled in managed care plans include individuals with physical, intellectual and/or developmental disabilities; individuals needing long-term services and supports (LTSS); aged, blind and disabled; and individuals who have multiple chronic conditions.

Concurrently, states have greatly expanded their contracting for managed LTSS in order to organize services in the community, rather than institutions, and manage spending. Lastly, most states have enrolled all individuals newly eligible for Medicaid due to the Affordable Care Act (ACA) expansion in managed care.⁵ In total, 39 states (including DC) enroll at least some Medicaid beneficiaries in risk-based Medicaid MCOs.⁶

Medicaid directors report that the field of quality measurement and improvement lags behind their needs.

Source: The Academy Health Listening Project, "Improving the Evidence Base for Medicaid Policymaking," 2015.

CURRENT APPROACHES TO QUALITY MEASUREMENT IN MEDICAID MANAGED CARE

When states expand or make changes to managed care, CMS requires that they have a plan for ensuring access and quality. States,

in turn, build these requirements into their managed care contracts. To monitor quality, most states select a preponderance of measures from the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). In 2016, 37 of the 39 states with risk-based Medicaid managed care plans required the plans to report at least some HEDIS® measures.⁷

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to measure quality in Medicaid managed care because it is validated by researchers and places only a modest additional burden on health plans, some of which are already reporting HEDIS® in the private sector or who may have been doing so voluntarily to gain accreditation from the National Committee for Quality Assurance (NCQA). HEDIS® defines a set of measures for Medicaid managed care plans, though the vast majority of measures overlap with those for commercial plans.⁸ Currently, there are seven measures in the Medicaid set that are not in the commercial set, such as screening of children for lead poisoning, which is of greater concern among children living in poverty.⁹ Historically, other measures, such as colorectal cancer screening for older adults, have not been clinically appropriate for the vast majority of Medicaid managed care enrollees, and thus were excluded from the Medicaid set.

States are not required to use HEDIS® or any standard set of measures and, in fact, many add their own measures or use their own specifications for HEDIS-like measures. In a study of state- and regionally-mandated measure sets, capturing the activities of

HEDIS[®] and CAHPS[®]

HEDIS[®] began as a strategy for private employers to assess whether health plans were meeting their expectations for quality. Lacking sufficient expertise to define quality, employers supported the creation of NCQA to promulgate standards. Through extensive testing and expert guidance, NCQA created the set of measures known as HEDIS[®]. Some measures have a prevention focus, such as the percent of children receiving recommended well-child visits. Others focus on care for chronic conditions, such as the proportion of patients with diabetes who receive annual eye exams. The HEDIS[®] measures evolve along with medical standards.

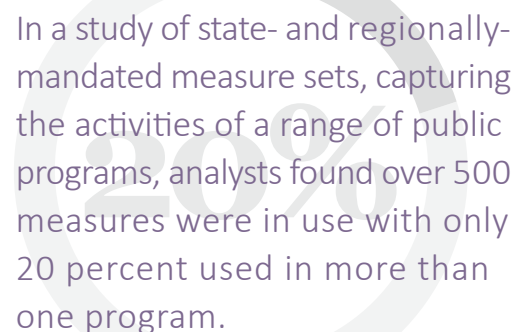
One of the reasons so many states have adopted HEDIS[®] for health plan reporting is that it relies almost exclusively on existing data rather than requiring new data collection. HEDIS[®] is almost entirely based on measures that can be derived from claims data, though a few do require chart review. Another strength of HEDIS[®] is that NCQA standardizes the way that plans report and audit the data, which allows comparisons between plans, and provides a national benchmark to support quality improvement activities. On the downside, HEDIS[®] does not capture all dimensions of quality.

The CAHPS[®] health plan survey asks enrollees about their experiences with their health plan and health care providers, such as getting access to the care they needed, getting care quickly, ease of communication with their providers, and the customer service of their health plan. CAHPS[®] endorses a concept that was previously met with skepticism—that patients' experiences of the health care system are indicators of quality. CAHPS[®] is a free-standing survey, though health plans generally report survey results as part of HEDIS[®] data collection. There are several key challenges when it comes to using CAHPS[®], such as sample size, low response rates, cost of conducting the survey, and no capacity for gathering detailed comments from consumers. These challenges can make it difficult to compare quality among providers or for subpopulations of enrollees.

Most states require that health plans report other quality metrics that are relevant to state initiatives. For example, 26 states promote the use of a medical home, and most are tracking the impact of medical homes by having health plans report the rate of Medicaid enrollees using the emergency room for conditions that could have been managed in a medical home.¹⁴

Regardless of the measures, their usefulness for quality improvement is enhanced when they are in place long enough to see trends (e.g., for three to five years) and assess whether interventions are having an impact, but not so long to the point where a state sees diminishing returns. Changing measures after one year or in the middle of a year makes such assessments difficult. Multi-year implementation of quality measures provides the opportunity for MCOs and the state to collaborate on continuous quality improvement activities that make sure high-quality outcomes are achieved for members and the state Medicaid program. Rotating a smaller number of targeted quality measures over a three to five year period while setting high goals for improvement may enhance and sustain quality improvement in the long-term.

a range of public programs, analysts found over 500 measures were in use with only 20 percent used in more than one program.¹⁰ Among all quality measures collected, many are collected by just a single state. Examples include: asthma medication ratio (Kentucky); employment among adults with mental illness and/or developmental disability (Michigan); percentage of antibiotics of concern (Kansas); and, pneumonia vaccination (Wisconsin). Three states (Arizona, Iowa and Rhode Island) collect care coordination measures, though each state's measure is different from the others'.¹¹ States frequently modify measures to their own specifications, as well. Just 59 percent of required measures were in their standardized form, 17 percent were for conditions often measured (e.g., asthma), but modified, and 15 percent of measures were state-created. When states tweak and adapt measures, payers, consumers, and providers lose one of the benefits of standardization in quality measurement—the chance to compare performance between states or between state and national average performance and begin to identify best practices.^{12, 13}



In a study of state- and regionally-mandated measure sets, capturing the activities of a range of public programs, analysts found over 500 measures were in use with only 20 percent used in more than one program.

THE CHALLENGES OF MEASURING QUALITY IN MEDICAID MANAGED CARE PLANS

Content Highlight

This section explores three major gaps in quality measures: outcomes measures, measures for populations with complex health care needs, and challenges with Medicaid data.

The abundance of metrics notwithstanding, more targeted metrics would be valuable, yet gaps in quality measurement present challenges. Among the many areas with little to no metrics available, the ones most notable for Medicaid are for behavioral health and LTSS, as well as measures for high-risk, high-cost populations such as individuals eligible for both Medicaid and Medicare (dual eligibles), the frail elderly, individuals with severe mental illness, and individuals with multiple chronic illnesses.¹⁵ Generally, the lack of measures in these areas is due to strategic decisions to rely on readily available data or a lack of research on which to base new quality measures.

This section explores three major gaps in quality measures: out-

comes measures, measures for populations with complex health care needs, and challenges with Medicaid data.

Process versus Outcomes Measures

Receiving care does not guarantee good outcomes nor does it guarantee improved health status. Measures that assess whether individuals got the right care (“process measures”)—long relied on to assess quality—are weaker alternatives to measuring the real goal: did individuals’ health and quality of life improve? In Medicaid and more broadly, outcomes measures such as “return to optimal health” or “regaining stability at home” remain the gold standard. The difference between process and outcomes measures can be illustrated by the example of diabetes care. When individuals with diabetes have blood sugar levels within the range that medical professionals have deemed stable and sustainable, health status is improved. If individuals’ blood sugar levels are above that range, they may develop debilitating problems such as loss of eyesight and sensation in their feet. HEDIS[®] uses claims data to learn if the doctor checked the individual’s blood sugar level, eyes, and feet. However, claims do not include the results of tests nor do they indicate if the doctor modified care for the individual based on those test results. Currently, health plans, providers, or others must manually review patients’ charts in order to measure outcomes like control of diabetes; this is time consuming and expensive.

The science of understanding outcomes also limits the development of more outcomes measures. Measure specification is complicated when there is a lack of consensus on what is considered an optimal outcome. For example, quality of behavioral health care is particularly difficult to measure, and as a result, existing measures focus on likelihood of getting services, rather than beginning and endpoints of health. The relevant HEDIS[®] measure, for example, captures whether a member with a behavioral health diagnosis who is discharged from the hospital is seen by a behavioral health provider within seven days. It does not measure if outpatient care

continued over time or if the member’s health status or functioning returned to the highest achievable level.¹⁶ Further, outcomes may take months or years to become evident, during which time patients may change plans or lose Medicaid coverage.

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Lastly, some outcomes are dependent on services delivered outside of the health care system and therefore are not measured. For instance, stable housing, the availability of healthy food, and transportation to doctors’ appointments are not incorporated in health outcomes measures but represent critical services and supports for many individuals.

The Need for Measures for Populations with Complex Health Needs

As individuals with special or complex needs are increasingly enrolled into managed care, standards-setting organizations such as NCQA need to build and states should utilize evidence-based quality measures that consider both the needs and preferences of this population. Interviews with state and federal policymakers, non-governmental experts, and other stakeholders have revealed gaps in accurate measures of quality, particularly for populations with complex or special health care needs.¹⁷ These include dual eligibles, individuals with severe mental illness, individuals with intellectual or developmental disabilities (ID/DD), and those requiring LTSS. With no national standards at this time, states have implemented various measurement requirements. For instance, a review of Medicare-Medicaid Plans (Financial Alignment Initiative) found a number of quality reporting requirements are used across multiple states. These measures supplement some traditional managed care quality measures with indicators that target individuals age 65 or older and those with complex medical needs, and acknowledge the importance of medication management and transitions across care settings.¹⁸

- Receipt of a flu shot prior to flu season
- Screening for clinical depression and follow-up
- Enrollees with a problem falling, walking, or balancing who discussed it with their doctor and got treatment for it
- Enrollees who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year
- Enrollees with a prescription for oral diabetes medication who get and take their medication
- Appropriate transitions between care settings, and with care coordinator involvement
- Getting appointments and care quickly
- Hospital discharge activities to prevent readmissions

Among the many areas with little to no metrics available, the ones most notable for Medicaid are for behavioral health and LTSS, as well as measures for high-risk, high-cost populations such as dual eligibles, the frail elderly, individuals with severe mental illness, and individuals with multiple chronic illnesses.

This highlights the need for standards-setting organizations to develop more tailored and appropriate measures for these complex populations. These measures should cover aspects of care coordination, as well as outcomes related to functional ability, independence, and quality of life. Regarding managed LTSS programs specifically, experts have also pointed to the need to develop quality measures that include the programs' impact on "rebalancing"—shifting care from institutional settings to the community. They call for "the development of uniform or standardized measures to consistently assess the extent of rebalancing and evaluate home and community-based services (HCBS) quality in a way that allows meaningful comparison by stakeholders."¹⁹

CMS, states, NCQA, the National Quality Forum (NQF), and others have undertaken multiple efforts to develop quality frameworks and test measures for LTSS, HCBS, and/or for populations such as those dually eligible for Medicare and Medicaid. These initiatives, which include pilots and workgroups, will inform development of Medicaid quality measures for populations with complex health care needs.

Challenges with Medicaid Data

The lack of available, reliable data other than claims presents another challenge for Medicaid agencies and for quality measurement generally, particularly for assessing health outcomes. While a small set of quality measures relies on chart reviews and member surveys (including CAHPS[®]), the majority of data used to measure quality come from health care claims (bills) submitted by health care providers such as hospitals, doctors, home health agencies, and pharmacies. In fact, claims data are the basis for most HEDIS[®] measures. By and large, claims describe what billable care was provided to a patient, but cannot describe

what non-billable care was provided, nor how the patient was affected by the care. Non-HEDIS measures often pose greater challenges due to lack of adequate standards on data collection (e.g., some measures are not amenable to computer programming), reporting, auditing, or benchmarks to evaluate reported outcomes.

Additionally, as states have moved away from paying claims to paying a capitated or risk-based payment to managed care plans, states are losing some essential process data. Managed care plans are required to report encounter data, and most do. However, some encounter data sets are less complete and harder to use.²⁰ For example, data needed to develop measures targeted at new populations (e.g., individuals with ID/DD or individuals with serious mental illness) or new services (e.g., LTSS) in managed care are often recorded in charts or case-worker files—and not included in encounter data sets. Bundled payments to providers make it even more difficult for health plans and other stakeholders to examine data on a granular level. Further, Medicaid member data tends to be fragmented since members do not always stay in one MCO. More work is needed for encounter data to be as useful as claims.

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There is a growing interest in the information that patients and families can report about their experience of care. CAHPS® surveys are widely used. However, the patient surveys are expensive and the respondents' providers are not identified, limiting the ability of health plans to target quality improvement efforts on subpar providers. Also, the survey is generally conducted just once per year, and the response rate tends to be low and/or the number of people surveyed is typically too small to get a nuanced view of quality—particularly since there is no place for the survey taker to write in comments. Another concern is that CAHPS® is not an effective survey for consumers with low literacy, cognitive impairment, or other communication barriers because of its length and the inability to modify it.

OUTLOOK FOR IMPROVING QUALITY MEASUREMENT

Content Highlight

There are several activities underway that hold promise for quality measurement, particularly for Medicaid managed care.

Electronic Medical Records

Electronic medical records (EMRs) will help health plans gather and analyze information from providers that is documented in medical records but not captured in claims, such as care plans, receipt of care, and the impact of care on health status. For example, an EMR makes easy (relative to paper records) for providers to document care coordination by storing information from referrals. In addition, EMRs have charting capacity that makes it easier to monitor vital statistics and know whether patients are improving (or stabilizing). Other

features like problem lists and medication lists can also be tapped for quality monitoring.

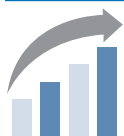
There remain some challenges to realizing the benefits of EMRs for quality measurement. For example, provider participation in CMS's second stage of its "Meaningful Use" initiative—which provides payments to Medicaid and Medicare providers who show that they use key features of their EMRs to improve care—is modest. Further, national physician surveys find that only a small fraction of those with EMRs are using them to coordinate care across providers or monitor patients' vital statistics.²¹

Despite providers' relatively slow embrace of EMRs for quality improvement to date, policymakers, payers, and many providers remain committed to moving toward greater use of EMR data to track processes and outcomes, identify gaps in care, and develop quality improvement initiatives. This will require efforts to facilitate storing of information in EMRs in ways that are more easily extracted and analyzed (e.g., use of searchable fields rather than narratives or attachments).

CMS Efforts

CMS is helping to spur improvements in quality measurement in “less traditional settings” by undertaking a number of initiatives. In April 2016, CMS released the first major overhaul of managed care regulations for Medicaid and CHIP in over a decade.²² With respect to quality measurement and reporting, the final rule requires states contracting with Medicaid MCOs to develop and implement a quality rating system (QRS) over the next three years. CMS expects to determine a core set of measures and corresponding methodology for all MCOs, as well as the structure and process of the overall rating system, through a three-year multi-stakeholder process

that will include state Medicaid officials, health plans, consumer groups and experts in the quality and performance measurement



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field. At a minimum, CMS will develop a QRS that aligns with the methodology and indicators of the QHP quality rating system:²³ 1) clinical quality management; 2) member experience; and 3) plan efficiency, affordability, and management. According to the rule, states will be able to use an alternative methodology or adopt additional measures for use in the rating system, as long as it is “substantially comparable” to the QRS and is approved by CMS. The regulations also require that states “prominently display” the health plan ratings, ensuring that beneficiaries have access to the quality ratings at enrollment so that they can use them when choosing a health plan.

Under the ACA’s charge to implement a process to provide input and gain consensus on quality and efficiency measures considered for public reporting and performance-based payment programs, CMS is receiving guidance from the Measure Applications Partnership (MAP). Convened by NQF,²⁴ MAP is a multi-stakeholder workgroup—including providers, payers, researchers, and others—that reviews standards for performance measurement and guides their use in particular programs. MAP deliberations consider how the CMS-proposed measures relate to process and outcomes of care, as well as the level of difficulty of data collection. For example, NQF has been asked to assess and recommend quality measures for HCBS that are:^{25,26}

- Targeted – measuring the right care for the right patients in the right setting;
- Validated by researchers;
- Focused on health outcomes and quality of life;
- Reflective of patients’ (and sometimes family members’) experiences with providers and plans;
- Feasible and not overly burdensome to collect, ideally from existing data;
- Integrated with community-based services; and
- Developed with patient and family input.

Through these and other efforts, CMS continues to work with states and key stakeholders on quality measurement development and quality improvement activities in Medicaid.

Core Measure Sets

In 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) directed CMS to define a set of child health quality indicators that is broadly applicable to children enrolled in Medicaid or CHIP, whether in a managed care plan or not. State Medicaid agencies now use these measures to establish the value of the health services they are purchasing and set priorities for improvement. Previously, there was no widely used set of measures that pertained specifically to children, nor was CMS able to describe the state of quality of care for children in Medicaid and CHIP.

As a practical matter, the measure selection committee prioritized measures that were feasible for states to report immediately while also relevant to the services most important to the health of children.²⁷ As a result, the Child Core Set includes many HEDIS® and CAHPS® measures because they were already widely in use and/or based on available data. After a ramp up period, all

states reported at least two Child Core Set measures to CMS for 2013 (the two were Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures reported to CMS already), and 33 states reported at least 13 of the 25 core measures in 2013.²⁸ The core set is updated annually as new measures and data permit. As of 2016, there are currently 26 child core measures.²⁹ States voluntarily report data to CMS for measures in the Child Core Set.

The Adult Core Set was subsequently mandated by the ACA. Its development followed the same vetting and selection process as for the Child Core Set, with input from states, quality experts, providers, and consumer advocates. Fewer states report adult core measures than report the children's, with 30 states reporting one or more core measures and 25 states reporting eight or more measures in 2013.³⁰ The 2016 Adult Core Set is comprised of 28 measures, primarily HEDIS® measures,³¹ CAHPS® survey measures,³² and Prevention Quality Indicators, and is updated annually with guidance from NQF.^{33,34} State reporting on Adult Core Set measures is also voluntary.

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Bringing Consumers' Experiences Forward

Public and private entities—such as government agencies, national associations, and research organizations—are seeking input from patients about their care and its impact on their health and well-being. With further development, it is conceivable patient feedback could be used to measure quality in Medicaid programs. For example, National Core Indicators-Aging and Disabilities (NCI-AD) is an initiative to assess how states' LTSS systems are impacting consumers' quality of life.³⁵ Patients are interviewed at care sites about their health and well-being, regardless of insurance source. Some data are also collected through a survey mailed to individuals. This survey tool could be a valuable source of comparative state quality information in the Medicaid program. Thirteen states collected and reported data in the 2015-2016 survey year, and more are expected to participate in the future.³⁶ NCI-AD is a joint undertaking of the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute.

Researchers are developing other ways of gathering and reporting information about quality, particularly to enhance our understanding of patients' needs. For instance, CAHPS® developers are studying ways that patient narratives could be incorporated to provide more depth and breadth to the information on patients' experiences. In addition, the Agency for Healthcare Research and Quality (AHRQ) is involved in the development of a new version of CAHPS® that will take into account an individual's health literacy level, thereby making it possible to gather better and more accurate information about the experiences of individuals with low health literacy.³⁷ Also, the National Institutes of Health (NIH) are developing and validating new measures of patient-reported physical, mental, and social well-being for children and adults.³⁸ Questions assess patients' experiences with typical activities of daily life. For example, "are you able to walk a block on flat ground?"³⁹ Several sets of measures are currently being developed and tested and may soon be available for broader use.

Core Quality Measures Collaborative

In February 2016, the Core Quality Measures Collaborative—a group of stakeholders including NQF, CMS, America's Health Insurance Plans (AHIP), primary care and specialty providers, and health plans—released a set of quality measures on which to build a more standardized quality measurement approach. The goal of the Collaborative is to "promote a simplified and

consistent process across public and private payers by reducing the total number of measures, refining the measures, and relating measures to patient health.”⁴⁰ Key principles include, among others, measuring outcomes rather than processes; investing in the basic science of measurement development and applications including an emphasis on unintended adverse consequences; and tasking a single entity with defining standards for measuring and reporting quality and cost data to improve the validity, comparability, and transparency of publicly-reported health care quality data.⁴¹ It is too soon to tell the extent to which this core set will be adopted by CMS, state Medicaid agencies, and health plans. Some stakeholders have concerns that new core sets, especially if lacking adequate specifications for collection and reporting, may become an administrative burden to both health plans and providers.

CONCLUSION

Expectations are high that health care reforms such as value-based payments and medical homes will improve quality of care and health outcomes while moderating health care spending. In Medicaid, the emphasis on quality is especially acute in states that are moving more beneficiaries into managed care plans and/or shifting delivery of long-term services and supports to homes and communities. Quality measurement is essential for judging the impact of changes like these on the individuals they are intended to benefit.

In response, states are designing their own quality strategies and, at the same time, CMS has finalized a plan for new national standards for measuring the quality of Medicaid managed care plans. Payers, providers, and quality measurement organizations also are shaping quality measurement strategies by convening multiple workgroups, developing recommendations for new measure sets, and testing new measures in select states’ Medicaid programs.

As this work continues, it is important that quality measures are well-tested, evidence-based, peer-reviewed, and focused on measuring the health outcomes of individuals. In addition, measure developers should pay particular attention to populations and services not historically well represented by quality measures, such as individuals with behavioral health conditions, individuals with intellectual and/or developmental disabilities, and managed LTSS.

It is important that quality measures are well-tested, evidence-based, peer-reviewed, and focused on measuring the health outcomes of individuals. In addition, measure developers should pay particular attention to populations and services not historically well represented by quality measures.

This paper is the first of three issue briefs focused on quality measurement and reporting in Medicaid; the others are available at <http://anthempublicpolicyinstitute.com>. The Anthem Public Policy Institute gratefully acknowledges the support of Health Management Associates in the research and writing of this paper.

END NOTES

- ¹ Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., & Hinton, E. (2015, October). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016 (Rep.). Retrieved May 2, 2016, from The Henry J. Kaiser Family Foundation website: <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>
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- ³ Ibid.
- ⁴ The Henry J. Kaiser Family Foundation. (n.d.). Medicaid Spending Per Full-Benefit Enrollee. Retrieved June 02, 2016, from <http://kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/>

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- ⁷ The number of states with risk-based managed care plans comes from the Henry J. Kaiser Family Foundation. Of these states, the number that report at least some HEDIS measures come from: National Committee for Quality Assurance. (2016, April). State Use of HEDIS for Medicaid (April 2016) [PDF]. Retrieved May 26, 2016, from http://www.ncqa.org/Portals/0/Public%20Policy/Attachment%208%20-%20List_Medicare%20HEDIS_April%202016.pdf?ver=2016-04-20-140222-233
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Table EQR 5. Performance Measures for Medicaid and CHIP Managed Care Plans That Evaluate Care Provided to Adults, as Reported in External Quality Review (EQR) Technical Reports, 2013-2014 Reporting Cycle.

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The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem's innovative programs.

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