# Balancing Standardization and State Flexibility in Medicaid Quality Measurement and Reporting

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## Contents




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# INTRODUCTION

**Content Highlight**

This paper examines the variation in current state approaches to quality measurement for comprehensive, risk-based Medicaid MCOs, and discusses the balance between standardization of measures and state flexibility to use state-specific measures.

State quality measurement systems intended to hold Medicaid managed care organizations (MCOs) accountable are at a crossroads. Current federal requirements give states the flexibility to design their own quality measures and standards, resulting in states tailoring their quality programs to their specific populations enrolled, sets of benefits, health gaps and trends. States vary in the number and type of quality measures that they use to monitor outcomes and the ways in which they hold health plans accountable for quality improvement. New federal regulations finalized by the Centers for Medicaid & Medicaid Services (CMS) emphasize greater consistency in quality measures across states and greater alignment across programs.

This paper examines the variation in current state approaches to quality measurement for comprehensive, risk-based Medicaid MCOs, and discusses the balance between standardization of measures and state flexibility to use state-specific measures. While a flexible approach affords states' the customization that exists today, a more standardized approach would allow for national benchmarking and possibly reduce the level of effort associated with measure collection and reporting.

It will be challenging but essential for policymakers to find a balance for quality measurement and reporting that realizes the benefits of using standardized, transparent, evidence-based measure sets, as well as the rewards from flexibility to innovate and address state-specific needs and circumstances. States and the federal government should partner with stakeholders and experts in quality measurement—including health plans—to find the optimal balance.

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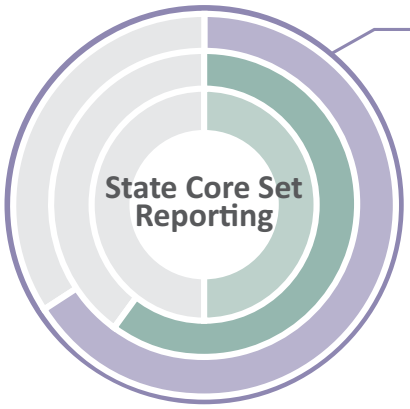
# CURRENT FEDERAL STANDARDS AND RULES

Under current federal requirements regarding Medicaid MCO quality, states must develop comprehensive quality strategies, measure MCOs' performance regularly, require health plans to complete performance improvement projects (PIPs), and contract with an External Quality Review Organization (EQRO) that reports quality information to the state. Within these federal guidelines, states have much flexibility to design their quality measurement systems including selecting the metrics, developing specifications for reporting, establishing benchmarks and goals, devising topics for PIPs, and creating incentives tied to quality measures such as pay-for-performance and value-based payments.[1]

The Children's Health Insurance Program Reauthorization Act (CHIPRA) and the Affordable Care Act (ACA) included provisions that shift the CMS and states toward a national system for measurement, reporting, and quality improvement. The Acts required development of "core sets" of health care quality measures for Medicaid and CHIP-enrolled children and adults in both managed care and fee-for-service (FFS). In 2016, the Child Core Set has 26 measures,[2] and the Adult Core Set is comprised of 28 measures, primarily HEDIS® measures,[3] CAHPS® survey measures,[4] and Prevention Quality Indicators.[5,6] An annual report on the quality of care for children and adults summarizing state-specific and national information on Medicaid quality (managed care, FFS, and other models) is expected to be released every year. The annual CMS quality reports are publicly accessible, but CMS waits until a certain number of states are reporting a given measure before making the rates known. This is designed to account for the differences in states' Medicaid-enrolled populations.

Because state reporting of the Child and Adult Core Sets to CMS is voluntary, the measures are not universally or consistently reported. All states voluntarily reported at least two Child Core Set measures to CMS for federal fiscal year (FFY) 2013, and 33 states reported at least half (13 of 25) of the core measures.[7] Thirty states reported one or more adult core measures and 25 states reported eight or more adult measures in 2014.[8] Additionally, the core measures cover both FFS and managed care; they do not compare health plans, and they are not necessarily tied to state measures or ratings that are publicly reported to consumers.




In April 2016, CMS released the first major overhaul of managed care regulations for Medicaid and CHIP in over a decade.[9] With respect to quality measurement and reporting, the final rule requires states contracting with comprehensive risk-based Medicaid MCOs to develop and implement a 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 field. At a minimum, CMS will develop a QRS that aligns with the methodology and indicators of the QHP quality rating system:[10] 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.

## THE STATE OF STATE QUALITY SYSTEMS

### Content Highlight

States have much flexibility to design their quality measurement systems including selecting the metrics, developing specifications for reporting, establishing benchmarks and goals, devising topics for PIPs, and creating incentives tied to quality measures such as pay-for-performance and value-based payments.

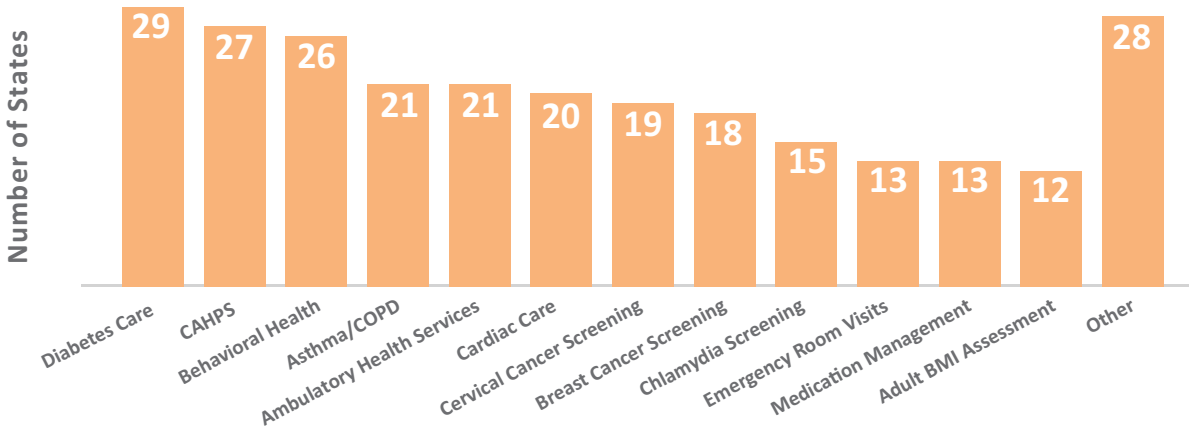
As part of an overall quality strategy, each state not only specifies quality domains and measures for Medicaid managed care reporting, but may also promote transparency and create incentives around those metrics to drive quality improvement.

#### Quality Measures Collected and Reported

States vary with respect to the general areas of quality they monitor and the specific quality measures they collect, though there are commonalities.[11] Perhaps not surprisingly, states are focused on many of the same aspects of quality, such as diabetes care, consumer experience, and behavioral health, but the specific measures that they rely on to monitor MCOs' quality along these dimensions varies. Figures 1 and illustrate some of the more common areas of focus with respect to managed care quality for both adults and children. As the figures indicate, even at the topic level, there is no one area of quality measured by all states.[12]

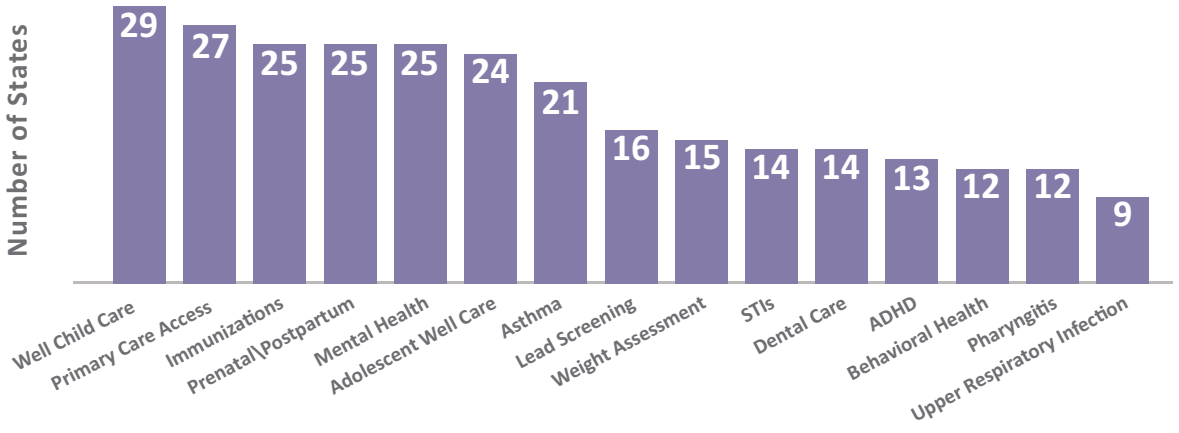
In addition, even when states share a similar area of focus, there is variation in the amount of emphasis, or weight, that a state places on that aspect of quality. For example, Pennsylvania reported seven adult asthma/COPD measures but just one adult mental/behavioral health measure, while Michigan reported two asthma/COPD measures but ten adult mental/behavioral health measures in 2013-2014.[13] Among child measures, Colorado emphasized behavioral health measures while Rhode Island reported the most care coordination measures in 2013-2014.[14]

### Figure 1. Number of States Using Medicaid Managed Care Performance Measure Topics Evaluating Adults




Source: Medicaid.gov (https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html), in Findings from EQR Technical Reports (adults), Figure EQR 1. Performance Measures Evaluating Adults Included in External Quality Review (EQR) Technical Reports for the 2013-2014 Reporting Cycle for 40 States, by General Topic.

### Figure 2. Number of States Using Medicaid Managed Care Performance Measure Topics Evaluating Children and Pregnant Women




Source: Medicaid.gov (https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html), in Findings from EQR Technical Reports (children), Figure EQR 1. Performance Measures Evaluating Children or Pregnant Women Included in External Quality Review (EQR) Technical Reports for the 2013–2014 Reporting Cycle for 40 States, by General Topic.

Delving deeper into each topic area, the specific measures reported by managed care plans may be the same across states. For example, 28 states required MCOs to report the HEDIS® Diabetes A1c testing measures for adults in 2013-2014, and 16 states required MCOs to report the HEDIS® lead screening measure for children in 2013-2014.[15] Yet, many states develop their own measures or tailor existing measures to their specific priorities. Nearly half of the adult measures used by states are not nationally recognized HEDIS®, CAHPS® or Core Set measures. Among all quality measures collected, many are collected by just a single state.

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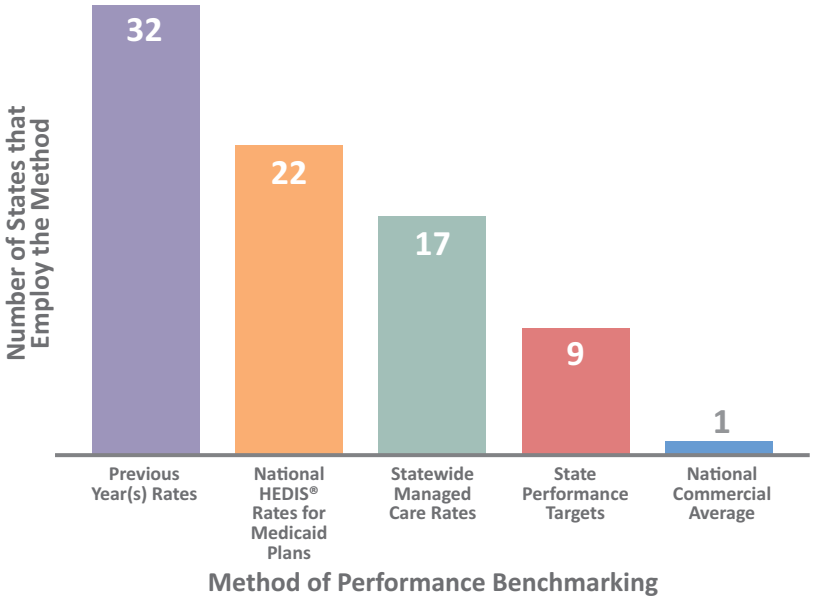
States also vary in how they assess quality performance and improvement, with some states using multiple approaches (see Figure 3). For instance, states might benchmark each MCO's performance against its previous years' rates in order to assess (and potentially reward) an MCO's improvement over time. Many states also track how well their Medicaid health plans compare with national HEDIS® Medicaid rates; this helps identify areas where the state as a whole needs to focus more attention. Some states set specific performance targets, motivating MCOs to focus on certain priority areas in order to achieve these goals.

States may assess health plans' quality overall or they may report performance for subgroups of beneficiaries, such as MCO enrollees receiving behavioral health services, or for geographic areas such as by county.[16] Current development of new metrics focused on specific populations will allow for more targeted assessment and improvement.

### Figure 3. Methods of Performance Benchmarking, Reported in External Quality Review Technical Reports, 2013-2014 Reporting Cycle (Adults and Children)




Source: Medicaid.gov (https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html), in Findings from EQR Technical Reports (adults), Figure EQR 4, and in Findings from EQR Technical Reports (children), Figure EQR 4. Reporting of Performance Rates for Measures Included in External Quality Review (EQR) Technical Reports, 2013-2014 Reporting Cycle.

The extensive number of quality measures used by states can place a sizable administrative burden on health plans and providers that are required to collect and report data on numerous metrics each year. MCOs that operate across multiple states encounter additional administrative complexities, due to the variations that exist in each state's quality program.

### Consumer Rating Systems

In states that share MCO quality information with consumers, the information is typically made available on states' websites and/or distributed to Medicaid applicants to help them select a plan. In 2014, 23 states publicly reported MCO quality metrics and another four states newly reported measures in 2015.[17] A subset of these states make the quality ratings more consumer-friendly, presenting the information in "report cards" that compare MCOs using a three or five "star" scale and/or presenting the information in composite measures that summarize plans' performance on key dimensions.

Medicaid MCO report cards directed at consumers vary across states and differ from report cards that may be available for commercial managed care plans within the state. Further, the quality measures collected and reported for consumer report cards do not necessarily match the measures used for Medicaid performance incentive programs linked to MCO payment. For example, Maryland's report card is heavily based on CAHPS® composite measures, whereas the state's value-based purchasing program is based primarily on HEDIS® measures with a few state-developed indicators (see text box).

## Maryland's Medicaid Managed Care Quality Strategy

Maryland requires MCOs in its HealthChoice Medicaid managed care program to collect and report all HEDIS® measures and CAHPS® survey results, meet or exceed the national average for applicable HEDIS® measures, meet or exceed the NCQA Quality Compass benchmarks for the CAHPS® survey, and receive NCQA accreditation.

Value-Based Purchasing Initiative: Maryland ties select HEDIS® and encounter data performance measures to financial incentives in alignment with evolving priorities and beneficiaries' health care needs The state uses a standard methodology to calculate "incentive," "neutral," and "disincentive" ranges, based on previous MCO performance. In 2015, the Value-Based Purchasing Initiative used 13 measures: 10 HEDIS® and three state-developed measures–two targeting the SSI population and one lead screening measure for children.[i]

Consumer Report Card: A Medicaid Consumer Report Card includes performance measures from HEDIS®, the CAHPS® survey, and the Value-Based Purchasing Initiative. It provides summary scores for six reporting categories:[ii]

- Access to Care
- Doctor Communication and Service
- Keeping Kids Healthy
- Care for Kids with Chronic Illness
- Taking Care of Women
- Care for Adults with Chronic Illnesses[iii]

MCOs are assigned three stars (above Maryland HealthChoice average), two stars (average), or one star (below average).

[i] Health Management Associates Interview with an Anthem Affiliated Health Plan's Subject Matter Expert [Telephone interview]. (2016, January 6).

[ii] Maryland Department of Health and Mental Hygiene. (2015, August 4). Medicaid Quality Strategy, HealthChoice Program: 2012-2016 [PDF]. Retrieved June 2, 2016 https://mmcp.dhmh.maryland.gov/healthchoice/Documents/2012-2016%20Maryland%20Medicaid%20Quality%20Strategy%20-%20Final.pdf

[iii] This was changed from Diabetes Care in 2015, to address the newly eligible adult population after the 2014 ACA-related Medicaid Expansion.

### Quality Improvement Initiatives and Policy Levers

States use the quality measures collected from Medicaid MCOs in various ways to hold plans accountable, supplemented by other improvement strategies. Most strategies are based on making quality metrics more transparent and using incentives to promote improvement:

- **Performance goals:** States create performance benchmarks, essentially establishing a minimum acceptable quality standard. For example, Virginia state officials selected 22 HEDIS® measures as quality improvement priorities for which its MCOs are expected to reach the 75th national percentile.[18] States can selectively contract with plans that meet the benchmark, or require plans that fall short to submit corrective action plans (CAPs).

- **Value-based payments (e.g., pay for performance (P4P), bonuses, and withholds):** States are increasingly designing P4P incentives and other value-based payment strategies that include lump-sum bonuses, higher capitation rates, or the release of a withheld portion of payment if the MCO reaches state-determined quality goals.[19] The goals may be a percentile of a state or national standard (e.g., 90th percentile of a national HEDIS® score), and/or a percentage increase of an MCO's prior score, indicating improvement. Quality improvement incentives may be integrated with incentives to drive appropriate utilization (and discourage inappropriate utilization). Texas' Medicaid managed care Pay-for-Quality Program, for example, ties financial incentives to MCO improvements on a set of nine HEDIS® and Potentially Preventable Events (PPEs) measures, integrating clinical quality and resource use (see text box).[20]

- **Quality-based auto-assignment:** Some states assign a portion of beneficiaries who do not choose a health plan to MCOs that perform better on certain measures; the incentive is a greater market share for MCOs.21

- **Performance Improvement Projects (PIPs):** As noted above, Medicaid MCOs are federally required to conduct PIPs, and states or health plans determine the topics based on areas in need of improvement.[22] States use PIP results to gauge MCO performance improvement, and many are moving to add penalties for not achieving certain thresholds.

State Medicaid agencies reported a mix of managed care quality improvement initiatives in place in State Fiscal Year (SFY) 2014, with expansions in both SFY 2015 and SFY 2016 (see Figure 4). The growing number and variety of initiatives illustrate states' understanding that there is no one "solution" for quality improvement. Rather, improving quality of care is complex, challenging, and requires multiple strategies, particularly around transparency and incentives.

## Texas' Medicaid Managed Care Pay-for-Quality Program

Under Texas' Pay-for-Quality (P4Q) program, Medicaid managed care plans that excel on meeting quality measures are eligible for a bonus of up to 4 percent of their capitation rate. Health plans that don't meet their measures can lose up to 4 percent of their capitation rate. The measures used for Texas STAR plans (covering primarily low income children and pregnant women), CHIP plans (covering low income children with income above Medicaid levels), and STAR+PLUS plans (covering people who have disabilities or are age 65 or older and with long term services and support needs) are different combinations of HEDIS® measures and Potentially Preventable Events (PPEs). Following are the measures for the 2016 calendar year:[i]

| Measures | STAR | CHIP | STAR+PLUS |
|---|---|---|---|
| HEDIS® Well-Child Visits in 3rd, 4th, 5th, and 6th year of life | X | X | |
| HEDIS® Adolescent Well-Care Visits | X | X | |
| HEDIS® Prenatal and Postpartum Care | X | | |
| HEDIS® Antidepressant Medication Management (AMM) | | | X |
| HEDIS® HbA1c Control <8 | | | X |
| Potentially Preventable Admissions | X | X | X |
| Potentially Preventable Readmissions | X | | X |
| Potentially Preventable Emergency Department Visits | X | X | X |
| Potentially Preventable Complications | X | | X |

In 2016, an MCO receives (or loses) points based on improvement (or decline) relative to its 2013 baseline performance (CY 2013 / HEDIS 2014), with a minimum acceptable baseline set at the NCQA 50th percentile for well-child, adolescent visits and AMM, the NCQA 25th percentile for prenatal, postpartum and A1c HEDIS® measures, and the state MCO mean for PPEs. For incremental improvement, the state is looking for a plan to close the gap between their prior year performance and the attainment goal by 15 percent. When calculating actual gap closure/gap widening, the state is looking at the plan's measurement year performance as compared to the prior year. Funds received from MCOs with negative points are redistributed to MCOs with positive points.

[i] Texas Health and Human Services Commission. (n.d.). HHSC Uniform Managed Care Manual, Performance Measures for Pay for Quality (P4Q) [PDF]. Retrieved June 2, 2016 https://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp6/6-2-11.pdf

**Figure 4. Number of States with Medicaid Managed Care Quality Initiatives, SFY 2014-2016**

| Measures | In Place (2014) | New/Expanded (2015) | New/Expanded (2016) |
|---|---|---|---|
| Public Reporting of Quality Metrics | 23 | 10 | 5 |
| Pay for Performance | 19 | 8 | 6 |
| Managed Care Payment Withhold | 18 | 11 | 10 |
| Performance Bonus or Penalties | 19 | 9 | 9 |
| Other Quality Initiatives | 4 | 4 | 4 |
| Any Quality Initiatives | 33 | 21 | 19 |

Note: Categories are not mutually exclusive.
Source: 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-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

## ADVANTAGES OF STANDARDIZED MEDICAID MCO MEASURES AND RATING SYSTEMS

In regard to Medicaid quality, "CMS believes that standardized reporting has the potential to strengthen quality reporting, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes."[23] Greater consistency in Medicaid managed care quality measures across states would facilitate national benchmarking, and potentially support a federal quality improvement agenda. Consistent metrics and specifications for collecting the data provide more opportunities for data support, data aggregation, meaningful comparisons, identification of best practices, and shared learning across state lines.

**Greater consistency in Medicaid managed care quality measures across states would facilitate national benchmarking, and potentially support a federal quality improvement agenda.**

Standard measures also enhance system alignment and reduce administrative burden on insurers, particularly those with Medicaid health plans in multiple states. National HEDIS® measures, for example, are programmed into HEDIS® software, so they are easier to collect than when states deviate and establish "HEDIS-like" measures. The software allows the plans to continuously monitor their rates throughout the year, identify problem areas, and attempt to address them.

The use of nationally recognized measures that most health plans already use for NCQA accreditation, along with uniform specifications for collecting the data, further allow a health plan to monitor and compare its performance with a larger cohort of peers rather than just its state competitors. Multi-state insurers could also compare performance across their own health plans in multiple markets and identify best practices among high-performing health plans that could be shared and promoted.

In contrast, health plans often do not get their results on state "home-grown" measures from the state contractor that analyzes encounter data until after the performance year, making it difficult to self-monitor and make mid-course corrections. Additionally, health plans may not know exactly how the individual measures roll up into each composite rating or how their composite measures are calculated—making it challenging to assess their performance and focus improvement efforts.[24]

# ADVANTAGES OF FLEXIBILITY IN QUALITY MEASURES AND RATING ACROSS STATES

**Content Highlight**

Flexibility allows states to tailor quality measures and quality improvement efforts to state-specific Medicaid populations, benefits, policies, challenges, and short and long-term goals.

While standardization has benefits, flexibility in Medicaid managed care quality measures and rating systems has important rewards. Flexibility allows states to tailor quality measures and quality improvement efforts to state-specific Medicaid populations, benefits, policies, challenges, and short and long-term goals. For example, states with Medicaid managed long term services and supports (MLTSS) programs may want to assess MCOs' ability to maintain or improve independence and quality of life among people with disabilities and multiple chronic conditions. Such measures may include rate of transitions to community-based care, avoidance of placement in an institutional setting, and readmission to a nursing facility within 60 days. Likewise, states that include behavioral health in their managed care programs will want to incorporate metrics relevant to individuals with mental health and substance use conditions, such as ER utilization and behavioral health inpatient readmission rates.

The following examples highlight states' efforts to tailor their quality measurement systems to meet specific needs and priorities:

- New York has measures focusing on comprehensive HIV/AIDS care, and is introducing new "recovery outcome" measures such as housing and employment for behavioral health managed care plans (see text box).[25,26]
- Tobacco use is a critical statewide issue in Kentucky. To help address the issue, the state created a hybrid measure that supplements HEDIS® administrative data with chart reviews to determine whether Medicaid enrollees are smokers and whether they are receiving assistance in quitting.[27]
- Michigan developed a measure for employment among adults with mental illness and/or developmental disability.[28]
- Three states (Arizona, Iowa and Rhode Island) collect care coordination measures, though each state's measure is different from the others'.[29]

State flexibility in quality measurement also promotes states' role as laboratories, granting them the agility and creativity to test new measures and improvement strategies that could be shared with and adopted by other states or payers.

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New York, for example, developed a metric for lead testing for two-year olds, which was later adopted by NCQA and is now a HEDIS® measure. Managed care plans might also adopt across multiple markets the quality improvements made in response to incentives in one state.[30]

State flexibility could allow states to align quality measurement and improvement across payers and programs within the state—for example, between Medicaid and the Exchange—which may reduce the data collection and administrative burden on providers and health plans in that state. To the extent states design quality rating systems that share similarities across Medicaid and the Exchanges, while accounting for program and population differences, consumers—who frequently "churn" between programs—may benefit from a similar plan selection experience and a familiarity of the scoring systems.

Finally, flexibility could foster more appropriate benchmark comparisons that take into account factors such as population and/or geographic variation. When states use standard measures and compare a health plan's results to national benchmarks, it is possible that the plan's (or a particular Medicaid program's) population has different characteristics and risk levels than the broad base used to determine the national benchmark. A health plan may be unfairly penalized for failing to meet the national benchmark if, for example, it is serving a rural area with few medical resources, or if the plan is serving large numbers of individuals with special health care needs. This argues for using "apples to apples" comparisons and benchmarking based on comparable populations or a health plan's prior performance.

## New York's Quality Monitoring Approach

New York has a multi-faceted approach to evaluate Medicaid managed care quality. The state requires Medicaid health plans to submit a range of measures (described below) annually, requires submission of HEDIS® or CAHPS® data to NCQA, and publicly releases quality reports.

**QARR:** New York developed its own set of Quality Assurance Reporting Requirements (QARR) for Medicaid managed care plans that pre-dated HEDIS®. QARR now includes a number of HEDIS®/CAHPS® measures, Prevention Quality Indicators developed by the Agency for Healthcare Research and Quality (AHRQ), utilization data, and state-specific measures that reflect the state's challenges and priorities. The major areas of performance included in QARR are:[i]


Effectiveness of Care


Access to/Availability of Care


Satisfaction with the Experience of Care


Use of Services


Health Plan Descriptive Information


State-specific measures: HIV/AIDS Comprehensive Care, Adolescent Preventive Care, and Prenatal Care measures

**Recovery Outcome Measures:** As the state transitions behavioral health services into managed care, New York's Health and Recovery Plans (HARPs), specialized MCOs for adults with certain diagnoses and serious behavioral health conditions, will report QARR measures and new "recovery outcome measures" reflecting social determinants such as employment, housing, criminal justice status, and functional status.[ii]

**Pay for Performance:** A P4P program links up to 3 percent of premium payments to quality and patient satisfaction measures. Since P4P began in 2001, performance has improved, and the quality gap between Medicaid and commercial managed care has narrowed.[iii]

[i] The New York State Department of Health Office of Quality and Patient Safety. (2015, September). Quality Strategy for the New York State Medicaid Managed Care Program 2015 [PDF]. Retrieved June 2, 2016 http://www.health.ny.gov/health_care/medicaid/redesign/docs/rev_quality_strategy_program_sept2015.pdf

[ii] New York State Department of Health. (2015, August). New York State Medicaid Update Special Edition - July 2015 Volume 31 - Number 7. Retrieved June 2, 2016, from https://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-07_speced.htm

[iii] Helgerson, J. A. (2015, July). MRT Update - Progress-to-Date, DSRIP and the Road to Value-Based Payment [PDF]. United Hospital Fund. Retrieved June 2, 2016 https://www.uhfnyc.org/uploads/Files/Presentations/2015_Medicaid_Jason_Helgerson.pdf

## BALANCING STANDARDIZATION AND FLEXIBILITY

**Content Highlight**

It will be challenging but essential for policymakers to find a balance for quality measurement and reporting that realizes the benefits of using standardized, transparent, evidence-based measure sets, as well as the rewards from flexibility to innovate and address state-specific needs and circumstances.

Recognizing the advantages to both standardization and flexibility in Medicaid managed care quality measurement across states, many stakeholders call for a balance. In interviews with quality measurement experts and health plan representatives, some suggest that states use a standard set of measures for national comparisons and benchmarking, while allowing for some supplemental measures that are state-specific to address state challenges and priorities.[31]

Alternatively, states could be encouraged to select from a "pool" of nationally-developed and recognized measures such as the Adult and Children's Core sets. This would promote consistency of metrics, methodologies, and specifications across states—allowing a certain degree of comparison nationally—while giving states the flexibility to determine which measures are most appropriate to their populations and priorities. Other payers (e.g., Exchange, commercial insurance) could also be encouraged to draw measures from this pool to promote "apples to apples" comparisons and reduce the administrative burden of collecting data on the same general measure but in multiple ways.

Many stakeholders point out that the use of standard measures does not preclude Medicaid programs from establishing different performance goals, depending on their starting places. For example, in one state, MCOs may be above the 90th percentile nationally on a certain measure, while in another state MCOs struggle to reach the 25th percentile. States could also develop different incentive strategies to reach the targets, depending on their own market dynamics and culture. Consumer rating systems and report cards may use similar measures across states but different relative rankings that compare health plans within a state rather than nationally. PIPs provide additional opportunities for states to focus on state-specific challenges and priorities. Experts interviewed emphasize that ratings and incentive programs should have transparent methodologies, with specific numeric goals set at reasonable levels.[32]

Finally, stakeholder input on measure set development helps ensure that experience and expertise, as well as administrative burden and other concerns, are considered and addressed. For instance, health plans regularly provide input to public and private organizations such as the National Quality Forum, NCQA, states, and CMS. Plans bring experience serving and assessing quality for various populations, such as those with LTSS and behavioral health needs, as well as perspective on broader topics, such as alternative measures that focus more on health outcomes (versus process measures).

## CONCLUSION

The challenge going forward is to determine the optimal balance whereby standardization of Medicaid managed care quality measures across states adds value—in terms of national benchmarking, consumer usefulness, and quality improvement—while flexibility allows state policymakers to be innovative and focus on specific needs of beneficiaries and areas in most need of improvement.

As CMS continues to develop a quality rating strategy, it should be mindful of the diverse needs of the populations served through Medicaid managed care as well as the work already done in many states to build successful quality strategies that offer tools and "best practices" to others. CMS can encourage states to use quality measures that are well-tested, evidence-based, peer-reviewed, and focused on measuring positive health outcomes of members. At the same time, states should continue to serve as testing grounds for innovative quality measurement and reporting approaches.

*This paper is the second 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.*

# ENDNOTES

[1.] Association for Community Affiliated Plans (ACAP). (2012, June). How States Can Leverage Medicaid Managed Care to Improve Health Care Quality [PDF]. Retrieved June 2, 2016 http://communityplans.net/Portals/0/fact%20sheets/2012_0621%20How%20states%20leverage%20Medicaid%20Managed%20Care%20to%20improve%20quality.pdf

[2.] 2016 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) [PDF]. (2016). Medicaid.gov. Retrieved June 2, 2016 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2016-child-core-set.pdf

[3.] National Committee for Quality Assurance. (n.d.). HEDIS® & Performance Measurement. Retrieved June 2, 2016 http://www.ncqa.org/HEDISQualityMeasurement.aspx

The Healthcare Effectiveness Data and Information Set (HEDIS®) consists of 81 measures across 5 domains of care. HEDIS® is a tool used by more than 90 percent of America's health plans to monitor performance.

[4.] Agency for Healthcare Research and Quality. (2016, March). About CAHPS. Retrieved June 02, 2016 https://www.cahps.ahrq.gov/about-cahps/index.html

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, developed by the Agency for Healthcare Research and Quality (AHRQ), ask consumers and patients to report on and evaluate their experiences with health care, including communication skills of providers and ease of access to health care services.

[5.] Agency for Healthcare Research and Quality. (n.d.). Prevention Quality Indicators Overview. Retrieved June 2, 2016 http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

Prevention Quality Indicators (PQIs), developed by the Agency for Healthcare Research and Quality (AHRQ), are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions," conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

[6.] 2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) [PDF]. (2016). Medicaid.gov. Retrieved June 2, 2016 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2016-adult-core-set.pdf

[7.] Burwell, S. M. (2014, November). 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP (Rep.). Retrieved June 2, 2016 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf

[8.] Burwell, S. M. (2014, November). 2014 Annual Report on the Quality of Care for Adults Enrolled in Medicaid (Rep.). Retrieved June 2, 2016 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdfhttps://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf

[9.] U.S. Department of Health & Human Services. (2016, April 25). Managed Care. Retrieved April 28, 2016 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

[10.] The Qualified Health Plan (QHP) Quality Rating System (QRS) is a reporting requirement of all Qualified Health Plan (QHP) issuers operating in the Health Insurance Marketplaces (or Exchanges). The QHP QRS is in beta testing in 2015 and 2016, for eventual release to consumers during the 2016 open enrollment period for the 2017 coverage year. The QRS measure set consists of 43 measures, 12 of which are survey measures that will be collected as part of the QHP Enrollee Survey (largely based on CAHPS®). In 2015, 29 measures were beta-tested and the remaining measures require 2 years of data and will be released in 2016. QHP scores will be calculated using a standardized methodology that includes rules for combining and scoring QRS measures through a hierarchical structure, resulting in one global score. Based on the scores, CMS will assign each QHP a star rating using a 1 to 5 scale. Ratings were not required to be publicly available in 2015, but will be going forward.

[11.] Variation and overlap in state quality measurement are demonstrated through EQRO reporting to CMS. States contract with EQROs to collect and review data from Medicaid MCOs to determine compliance with state standards for quality measurement and improvement, validate both measures and performance improvement projects (PIPs), and submit detailed annual reports to CMS. The general topics and specific measures collected and submitted by EQROs vary widely by state, but there are commonalities.

[12.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Findings from EQR Technical Reports (adults), Figure EQR 1. Performance Measures Evaluating Adults Included in External Quality Review (EQR) Technical Reports for the 2013-2014 Reporting Cycle for 40 States, by General Topic. Findings from EQR Technical Reports (children), Figure EQR 1. Performance Measures Evaluating Children or Pregnant Women Included in External Quality Review (EQR) Technical Reports for the 2013–2014 Reporting Cycle for 40 States, by General Topic.

[13.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

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.

[14.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Table EQR 5. Performance Measures for Medicaid and CHIP Managed Care Plans That Evaluate Care Provided to Children and Pregnant Women, as Reported in External Quality Review (EQR) Technical Reports, 2013-2014 Reporting Cycle.

[15.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

[16.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Table EQR 4. Reporting of Performance Rates for Measures Included in External Quality Review (EQR) Technical Reports, 2013-2014 Reporting Cycle.

[17.] The Kaiser Commission on Medicaid and the Uninsured. (2015, August 19). 50-State Medicaid Budget Survey Archives. Retrieved June 2, 2016, from http://kff.org/medicaid/report/medicaid-budget-survey-archives/

[18.] Association for Community Affiliated Plans (ACAP). (2012, June). How States Can Leverage Medicaid Managed Care to Improve Health Care Quality [PDF]. Retrieved June 2, 2016 http://communityplans.net/Portals/0/fact%20sheets/2012_0621%20How%20states%20leverage%20Medicaid%20Managed%20Care%20to%20improve%20quality.pdf

[19.] In turn, health plans often establish similar reward systems within their provider networks.

[20.] Texas Health and Human Services Commission. (n.d.). HHSC Uniform Managed Care Manual, Performance Measures for Pay for Quality (P4Q) [PDF]. Retrieved June 2, 2016 https://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp6/6-2-11.pdf

[21.] Association for Community Affiliated Plans (ACAP). (2012, June). How States Can Leverage Medicaid Managed Care to Improve Health Care Quality [PDF]. Retrieved June 2, 2016 http://communityplans.net/Portals/0/fact%20sheets/2012_0621%20How%20states%20leverage%20Medicaid%20Managed%20Care%20to%20improve%20quality.pdf

[22.] Also, CMS may specify, in consultation with states and other stakeholders, performance measures and topics for performance improvement projects that states require in their contracts with MCOs. States can define PIPs to include HEDIS® or quality improvement standards. (42 CFR §438.358, Section 438.240(a)(2).

[23.] Burwell, S. M. (2014, November). 2014 Annual Report on the Quality of Care for Adults Enrolled in Medicaid (Rep.). Retrieved June 2, 2016 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdfhttps://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf

[24.] Health Management Associates Interview with an Anthem Affiliated Health Plan's Subject Matter Expert [Telephone interview]. (2016, January 14).

[25.] New York State Department of Health. (2015, August). New York State Medicaid Update Special Edition - July 2015 Volume 31 - Number 7. Retrieved June 2, 2016, from https://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-07_speced.htm

[26.] Helgerson, J. A. (2015, July). MRT Update - Progress-to-Date, DSRIP and the Road to Value-Based Payment [PDF]. United Hospital Fund. Retrieved June 2, 2016 https://www.uhfnyc.org/uploads/Files/Presentations/2015_Medicaid_Jason_Helgerson.pdf

[27.] Health Management Associates Interview with an Anthem Affiliated Health Plan's Subject Matter Expert [Telephone interview]. (2016, January 14).

[28.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

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.

[29.] U.S. Department of Health & Human Services. (n.d.). Quality of Care External Quality Review (EQR). Retrieved June 2, 2016 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

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.

[30.] Health Management Associates Interview with an Anthem, Inc. Subject Matter Expert [Telephone interview]. (2015, December 17).

[31.] Health Management Associates Interview with Experts in the Quality Field including Representatives from Health Plans and Health Measurement Organizations [Telephone interview]. (2015, December to 2016, February).

[32.] Health Management Associates Interview with Experts in the Quality Field including Representatives from Health Plans and Health Measurement Organizations [Telephone interview]. (2015, December to 2016, February).

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