

CHCS

Center for
Health Care Strategies, Inc.

Performance Measurement in Fee-for-Service Medicaid: Emerging Best Practices

Prepared for:
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The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.

Executive Summary

Through health reform, Medicaid will soon provide vital health services for up to one quarter of all Americans. As the nation's major health care purchaser, it is critical for Medicaid to assure the best health care quality possible across *all* delivery models for *all* current and newly eligible beneficiaries. Well-designed performance measurement approaches are a must-have mechanism for identifying where programs are working and where there is room for improvement.

While most states have well-developed performance measurement approaches for managed care delivery systems, many are still struggling, for a variety of reasons, with how exactly to assess the quality of health care services within fee-for-service (FFS) programs. Although roughly 70 percent of the nation's total Medicaid population is in managed care, many beneficiaries with multiple chronic conditions and intense health care needs are in FFS. These individuals account for disproportionate health care spending — approximately 80 percent of total Medicaid outlays nationally.¹ Thus, developing tailored performance measurement approaches that address the quality and cost effectiveness of health care for the FFS population is imperative.

Through support from the California HealthCare Foundation, the Center for Health Care Strategies (CHCS), in collaboration with the California Department of Health Care Services (DHCS), sought to better understand how states are using performance measures for Medicaid FFS beneficiaries, particularly those with complex needs. This resulting report outlines emerging best practices for measuring the quality of FFS care culled from the firsthand experiences of nine states as well as numerous interviews with key stakeholders across the country. The lessons are useful for other states with large populations in FFS and can also inform national activities to standardize performance measures for adult Medicaid beneficiaries.

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Key recommendations from experienced states outlined in the report are:

- Involve providers and relevant stakeholders in the process of developing and collecting performance measures.
- Start with a small number of HEDIS measures — but be clear with caveats.²
- Look outside HEDIS for measures of behavioral health service delivery.
- Use a multi-faceted measurement set including both HEDIS and specialized measures.
- Set clear and reasonable goals for public reporting.
- Devote resources to auditing measures.
- Consider opportunities to use health information technology.
- Value the role of leadership in this process.

And finally, the states interviewed for this analysis noted that other states should “just do it” – that is jump in and test ways to assess the quality of FFS services to discover what works and determine how to refine piloted strategies. By building on lessons from existing states in designing effective performance

¹ *Medicaid and Managed Care: Key Data, Trends, and Issues*. Policy brief, Kaiser Commission on Medicaid and the Uninsured, February 2010.

² HEDIS, which stands for the Healthcare Effectiveness Data and Information Set, is a nationally recognized measurement set developed by the National Committee for Quality Assurance. For information, see <http://www.ncqa.org/tabid/59/Default.aspx>.

measurement approaches for FFS beneficiaries, states can advance opportunities to better serve current Medicaid beneficiaries as well as those who are newly eligible.

The nine featured states that report performance measures for FFS populations have generously shared their successes and challenges to inform the lessons outlined in this paper. We thank the many participants for their detailed explanations of their efforts to measure performance and for their commitment to improve health care quality for today's beneficiaries and tomorrow's newly eligible populations.

Background

The Center for Health Care Strategies (CHCS), in collaboration with the California Department of Health Care Services (DHCS) and with support from the California HealthCare Foundation (CHCF), launched a project in November 2009 to better understand how states are using performance measures for Medicaid fee-for-service (FFS) populations to drive program accountability and improvement.³ This project was designed to identify emerging state best practices, as well as challenges, in using performance measures for FFS Medicaid beneficiaries, in particular people who are eligible for Medicaid related to their status as aged, blind, and disabled (i.e., seniors and persons with disabilities, or SPD).

Around the country, a subset of high-performing Medicaid purchasers are using robust performance measurement systems to measure access, quality, and cost-effectiveness across delivery system models. Although HEDIS was originally designed to measure health plan performance, some state Medicaid programs are using these measures (and adaptations thereof) to track performance in FFS and primary care case management programs (PCCM). States are also developing new measures to better reflect the needs of people with chronic illnesses and disabilities.

The passage of the Patient Protection and Affordable Care Act (ACA) creates a new sense of urgency among states as they seek to measure quality and demonstrate program accountability for current Medicaid beneficiaries and millions more who will be eligible in 2014. Furthermore, the ACA requires that the Secretary of Health and Human Services develop a set of health quality measures for Medicaid-eligible adults in the same manner as the core set of child health quality measures established under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Therefore, states can benefit from learning how to apply best practices in performance measurement for Medicaid FFS populations. Organizations, such as the National Quality Forum and the Agency for Healthcare Research and Quality, involved in establishing national standards for adult beneficiaries can also learn from how pioneering states are assessing health care quality for adult populations, particularly those with complex needs.

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CHCS' interviews with nine states uncovered an emerging best practice approach that employs a multi-faceted measurement set including both HEDIS measures and more specialized measures for the SPD population. National HEDIS measures provide a benchmark for state policymakers to compare the performance of different delivery systems and identify the more effective option. Additionally, for states planning to transition beneficiaries from FFS to managed care (or vice versa), national HEDIS measures can be used to establish a performance baseline. A best practice approach, however, must also consider clinical actionable measures relevant to the SPD population. By using clinical measures that better reflect the needs of people with chronic illnesses and disabilities, states can identify opportunities to improve the quality of care and measure the impact of program interventions. As outlined within this report, a two-pronged approach that mixes HEDIS and specialized measures can help states enhance the accountability and quality of programs serving beneficiaries with chronic illnesses and disabilities.

³ A list of performance measures that state Medicaid programs are using for fee-for-service populations are included in Appendix 2.

Methods

To help state Medicaid agencies with large populations in FFS determine how to best develop a performance measurement system, CHCS undertook three activities:

1. Interviews with Key Stakeholders

CHCS conducted interviews with key stakeholders to gather information about the use of quality measures within Medicaid (see Appendix 1 for a list of interviewees). CHCS examined the use of quality measures for general populations in FFS as well as for beneficiaries with complex needs to get a comprehensive view of the measurement strategies being used in FFS. Interviewees included representatives of the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), other national organizations (such as the National Academy for State Health Policy and the National Partnership for Women and Families), as well as California health plans. In addition, CHCS identified and interviewed nine state Medicaid agencies that have firsthand experience developing or adapting performance measures for FFS populations: Alabama, Colorado, Indiana, Massachusetts, Missouri, New York, North Carolina, Oklahoma, and Pennsylvania. Of the states interviewed, most have collected and reported performance measures for their FFS population for several years. The majority of states collect these measures for their PCCM members or for enrollees in chronic care management programs. However, Massachusetts and Colorado stand out as states that have reported quality measures for FFS Medicaid beneficiaries for a number of years.

2. Performance Measures in Medicaid FFS Small Group Consultation

In January 2010, CHCS convened a group of state and national experts in performance measurement to discuss best practices and challenges in health care quality measurement for FFS Medicaid beneficiaries. Representatives from state Medicaid agencies, the federal government, and national organizations, including the National Committee for Quality Assurance and the Agency for Health Research and Quality, gathered in Washington, DC to share their expertise in performance measure selection, data collection, and public reporting.

3. Technical Users Group Meetings

A users group was formed to discuss the technical aspects of performance measurement in FFS Medicaid. During a series of teleconferences, representatives from state Medicaid agencies, national organizations, and several California health plans shared their experiences regarding: (1) identifying, updating, and adapting HEDIS measures; (2) determining the resources required to develop measures; (3) pinpointing data sources; (4) defining eligible populations and exclusions; (5) determining continuous enrollment; (6) dealing with data collection challenges; and (7) auditing HEDIS measures. The final call focused on analysis, reporting, and use of measures for pay for performance and quality improvement.

Key findings from the project are summarized in this report.

Goals of FFS Performance Measurement

Among the states that were interviewed, three core reasons for establishing FFS performance measures emerged:

1. **For states with robust FFS or PCCM delivery systems:** To identify opportunities to improve the quality of care and measure the impact of program interventions such as a new quality improvement initiative or chronic care management program;
2. **For states with both FFS and managed care delivery systems:** To compare the performance of the two systems, identify which is more effective, and inform both policymakers and beneficiaries; and
3. **For states planning to transition beneficiaries from FFS to managed care (or vice versa):** To establish a performance baseline for monitoring the impact of this transition.

Additional goals for FFS performance measurement noted by the interviewed states include:

- Developing an overall accountability and performance mindset;
- Creating a parallel structure for the PCCM (or FFS) program that allows monitoring of provider performance (i.e., “act like a health plan”);
- Encouraging healthy peer competition among providers and health plans;
- Using measures within a pay-for-performance system;
- Providing continuity of measurement when health plans exit the state or drop contracts for covering Medicaid beneficiaries.

While it is possible to have many goals, a state should have a clear sense of its most important goal or goals as this will drive many decisions regarding the design of a performance measurement system.

Measurement Selection and Adaptation

Since HEDIS was originally developed to measure managed care health plan performance, state Medicaid programs need to consider the potential advantages and disadvantages of using HEDIS measures to track performance of Medicaid FFS and PCCM programs. When adopting HEDIS measures, many methodological issues arise, such as: (1) accounting for differences in claims and encounter data collection; (2) applying standard enrollment periods to the denominator; and (3) adjusting the results based on health status or other differences. This section details the pros and cons as well as state strategies for adopting HEDIS measures for FFS.

Advantages of Using HEDIS Measures for the FFS System

HEDIS measures are useful for state Medicaid agencies in providing a nationally recognized and standardized tool to track and compare performance. Another general advantage of HEDIS is that measures are evidence-based and carefully vetted. While HEDIS originated as a measurement set for health plans, there are now measures specified for providers, which may be more relevant for FFS application. Since 1991, when the National Committee for Quality Assurance (NCQA) created HEDIS, the measurement tool has grown to encompass 71 measures across eight domains of care, as follows:

1. Effectiveness of Care;
2. Access/Availability of Care;
3. Satisfaction with the Experience of Care;
4. Use of Services;
5. Cost of Care;
6. Health Plan Descriptive Information;
7. Health Plan Stability; and
8. Informed Health Care Choices.

Approximately 25 percent of Medicaid beneficiaries are in plans that report HEDIS data.⁴ Currently, 34 states collect or require NCQA's standard HEDIS or CAHPS measures, making it possible to compare the performance across states on an "apples-to-apples" basis.^{5,6} Many state Medicaid agencies use national HEDIS measures to compare performance between FFS and managed care systems. In addition to being a standardized tool, HEDIS offers states a first step in measuring access, prevention, and chronic care. If states can separately report on these measures for the FFS population, this is a good proxy of performance.

Limitations of HEDIS Measures for the FFS System

Despite efforts to compare Medicaid FFS and managed care systems, most states interviewed recognized that in reality, comparability is extremely difficult to achieve. If states do not have the financial and human resources to support medical record extraction at the provider level, the health plans' rates, using hybrid methods (a combination of administrative and medical record-based data collection allowable in most clinical measures in HEDIS protocol) will usually be higher than FFS rates. The quality review

⁴ State of Health Care Quality Report 2009." National Committee for Quality Assurance, 2009. http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_2009.pdf

⁵ "State Recognition of NCQA." National Committee for Quality Assurance. <http://www.ncqa.org/tabid/135/Default.aspx>

⁶ CAHPS stands for the Consumer Assessment of Healthcare Providers and Systems program, a standardized set of surveys that ask consumers to evaluate their health care experiences. For more information about this Agency for Healthcare Research and Quality program, visit http://www.cahps.ahrq.gov/content/cahpsOverview/OVER_Intro.asp.

vendor Health Services Advisory Group (HSAG) has noticed in its Medicaid work that rates are extremely low to start in the FFS population compared to managed care and that it takes time to determine whether the lower rates are due to data issues or whether the quality differences are real. This is not unlike the experience of managed care, where some of the observed improvement in quality scores can be a result of improvements in data collection and reporting. Reasons for differences in the data sets will be explored later in the paper, but can arise from differences in payment systems or subcontracting arrangements with certain provider types. Pennsylvania is one of the few states that invests resources to improve the comparability of its HEDIS-like measures, e.g., by having the source code validated by an NCQA-certified auditor and using hybrid methodology for measures.

Another concern raised by states is the issue of comparability of the data because of the acuity of the populations covered by managed care versus FFS. In most states, managed care programs often cover healthier populations. States typically started managed care programs by enrolling those with Temporary Assistance for Needy Families (TANF) eligibility, leaving most people with disabilities (SPD population) in FFS. From a measurement perspective, the split results in managed care HEDIS measures that reflect a healthier population's experience, and FFS measures that may not be comparable. To mitigate the issue of comparability, a standard could be applied that states stratify the denominators for HEDIS measures by TANF and SPD eligibility codes. However, many consumer advocates worry that stratification along these lines would cause health care purchasers to accept lower rates on performance measures for the preventive services needed by persons with disabilities, such as flu vaccine.

It is important to keep the SPD population in mind when developing performance measures because this subset of beneficiaries has intensive health care needs and accounts for a large share of Medicaid spending. With well-constructed performance measures, states can better determine the quality of care that beneficiaries with disabilities are receiving, pinpoint areas for improvement, and determine strategies to curb unnecessary spending. However, most of the states and health plans interviewed have not yet adapted HEDIS measures to better reflect the needs of the SPD population. Alternatively, states can work together to encourage NCQA to incorporate mental health and disability measures into the HEDIS set of measures.

With all these caveats, most states interviewed encouraged the use of HEDIS-like measures for FFS populations, but suggested that other states should prepare stakeholders by explaining the inevitable differences with managed care plans' results. An alternative approach suggested by Oklahoma is to follow the HEDIS criteria to assess FFS performance, but not publish the FFS measures because it would not provide an "apples to apples" comparison with managed care.

Rationale for Adapting HEDIS Measures for the FFS System

States' goals and priorities for FFS performance measurement typically influence their decision of whether or not to strictly adhere to HEDIS specifications. States that put a lower priority on using measures as a means to compare performance of FFS and managed care plans may deviate from HEDIS specifications or abandon them completely for other measures. For example, Alabama, which uses performance measurement to implement a system of quality improvement called "Together for Quality," focused on developing measures for two chronic conditions — asthma and diabetes — based on state-specific clinical data. Additionally, states like Missouri recognize that they need to adapt HEDIS measures to gain buy-in from providers. Such states make modifications to HEDIS measures based on current evidence-based recommendations or guidelines for clinical care published by medical associations, a step that NCQA also performs on a national level. Considering the recent push for a single national measurement set for children as well as for adults under recent federal CHIPRA and

ACA legislation, states may want to embrace a more standardized measurement approach and adhere to national guidelines for performance measurement. Consistency with commercial plan measurement should also provide Medicaid with leverage over physicians and plans.

In sum, the specific HEDIS and HEDIS-like performance measures adopted by states naturally follow from the goals of the program. For states comparing managed care and FFS performance, the measures chosen mirror the requirements in managed care plan contracts. States interested in chronic care improvement have adapted measures from traditional evidence-based measures sets (e.g., for diabetes or asthma care). States developing new measurement programs have the opportunity to choose or adapt measures that fit their population profile and community. A summary of state performance measures can be found in Appendix 2.

Examples of Adapting HEDIS Measures for the FFS System

While some states adhere to HEDIS protocol as closely as possible, others modify the HEDIS measure specifications. A typical adaptation for FFS is to create a denominator that substitutes Medicaid eligibility in a given month rather than health plan enrollment. Another modification of HEDIS protocol is changing the length of the enrollment requirement for inclusion. This is usually done to expand the number of members eligible for measurement. For example, North Carolina found that if it used HEDIS criteria for continuous enrollment, it would not have sufficient beneficiaries for FFS measures. Lastly, some states use administrative data only to report on measures for which the health plans use hybrid methodology. However, this approach may only point out differences in data systems, not in the actual care delivery.

Using Non-HEDIS Measures

Several states have developed measures not based on HEDIS to track performance in their FFS populations. For example, Indiana created a set of “bounce-back” measures for emergency department (ED) and inpatient use. These new measures, introduced for 2010, report rates of beneficiaries who reappear in facilities within 30 days. In addition, several states have added measures apart from HEDIS measures to the clinical measurement set. For example, some states began to collect Body Mass Index (BMI), a measure of obesity, before it was added to HEDIS, and collect other outcome-oriented measures tailored to their populations. Local and national quality improvement projects have recently sought to link medical and mental health experiences using measures such as the rate of follow-up after hospitalization for mental illness. Further examples from states are discussed below.

Selection of Measures

Stakeholders offered numerous suggestions about which types of measures are feasible for collection and useful for assessing care delivery performance. Suggestions included:

- **Select measures that rely solely on administrative data.**

All of the states and health plans interviewed use administrative or claims-level data to collect HEDIS measures. Administrative data are computerized records that are gathered for program operations, but contain valuable health-related information that can be used for research and performance measurement purposes as well. Such data offers numerous benefits, including wide availability, no need for new data collection, large databases, and ability to analyze population subgroups separately. Therefore, state Medicaid agencies and health plans see administrative data as an attractive source for performance measurement data. Despite its strengths, administrative data also has limitations — it can be incomplete, contain errors, or be missing altogether. Also, there can be a long lag time between when the care was

delivered and when the claim is available for analysis. For example, if providers do not expect sufficient reimbursement on a claim, they are less motivated to submit it even though they have performed the service. In addition, administrative data provides limited clinical information. Nonetheless, given the current lack of availability of other data sources, many of the states recommended selecting measures that rely on administrative data in the short term. States interviewed suggested to start simply and initially use common CPT codes for office visits to collect access to ambulatory care and well-child care measures. Over the longer term, however, states will need to capitalize on the “meaningful use” measures for the Medicaid and Medicare electronic health record (EHR) incentive program and other performance measures that are more clinically based and can be captured on an EHR and exchanged between providers.⁷

▪ **Select measures with a business case.**

A handful of states use select HEDIS measures that address opportunities to improve performance/quality while reducing costs. North Carolina “started small” when selecting its measures, focusing on areas of need with a return on investment (ROI). Before selecting measures for its PCCM Medicaid beneficiaries, North Carolina conducted a study with the University of North Carolina that demonstrated an ROI for asthma disease management programs that achieved reductions in hospitalizations, ED visits, and expenditures. Recently, North Carolina moved from a disease-specific perspective to a composite approach, selecting measures related to managing the SPD population with comorbidities and building measures around the medical home model. This paper later describes how North Carolina uses such measures to drive quality improvement projects for its PCCM program.

▪ **Select measures that focus on overuse and misuse.**

Participants interviewed noted that performance measures frequently focus on underuse of care and fail to capture inefficient overuse and misuse of health care services. Indiana’s ED and inpatient “bounce-back” measures, described above, help pinpoint areas to improve care, enhance care coordination, and curb inefficient use of health care services (e.g., recurring, unnecessary ED visits).

States considering measures for FFS performance measurement can ask the following questions:

- Is there a source of standardized measurement for the condition/population/process of interest? Have the measures been nationally endorsed, e.g., through the National Quality Forum?
- What measures should the state use to direct accountability for improvement at the provider and/or payer levels?
- What is the state’s ability to truly measure performance with this specific measure? The only risk adjustment mechanism in HEDIS is through exclusion, and there is more of a possibility of selection bias with small sample sizes.
- How will the state explain measurement results to stakeholders? For example, not all HEDIS measures have a goal of 100 percent. This can be difficult to explain to stakeholders.

⁷ American Recovery and Reinvestment Act of 2009, Division B, Title IV, Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions, Subtitle A — Medicare Incentives, and Subtitle B — Medicaid Incentives.

Development and Implementation

States interviewed described the detailed processes of developing a measurement system, designing and reporting new measures, refining existing measures, and implementing the new measurement approach within their FFS programs.

Resources Devoted to Development and Implementation

Among the states interviewed, the resources devoted to and the processes of developing measures varied. During the interviews, three major themes surfaced.

1. Many states contract out performance measurement activity.

The majority of states contract for the data collection and auditing processes, allowing states to use internal staff for analytic and quality improvement work. See Table 1 on page 14 for a list of vendors.

2. States use various structures for staffing analytic work.

In some states, entire sections or divisions of state employees are dedicated to analytics, while other states divide the analytic work among program areas. In other states, only a few staff are devoted to this work due to the recent economic recession and subsequent state fiscal pressures. States may also partner with outside organizations or universities to develop performance measures, and in some cases, the partners donate time to support the work. For example, Alabama and Massachusetts have close ties with local universities to support performance measurement work. In addition, Alabama and Colorado collaborate with external advisory groups. Colorado has a voluntary yet highly committed advisory group and Alabama has the Together for Quality Clinical Workgroup, which is responsible for disease prioritization, choice of measures, developing measure specifications, and setting goals and benchmarks.

3. States disproportionately allocate resources for quality improvement and performance measurement to monitor managed care.

States that support both a managed care and a PCCM program noted that internal resources are often disproportionately devoted to managed care, because of CMS requirements. The Social Security Act requires states that operate Medicaid managed care programs to provide an external, independent review of their managed care organizations.

Timeframe

For the majority of states interviewed, it took approximately one year from the start of developing a new measure to reporting it. The timeframe varied by the complexity of the measure (i.e., whether or not it was obtainable with administrative data alone) and whether or not the state had in-house analytic capacity. States with no internal decision-support system reported that creating the baseline for a new measure could take as long as six months. However, even with an internal decision-support system, it took one state over six months to clarify specifications and derive baseline measures.

Staffing

States typically seek to build a performance measurement team that includes staff with clinical and analytic expertise. One state interviewed is fortunate to have this mix of expertise in one staff member — an RN trained in medical informatics. Several states reported having a combination of master's

prepared statisticians and programmers on staff. Typically, two or three staff members are dedicated to measurement activities, with as few as 0.2 FTE staff responsible for the development stage.

Process of Developing and Identifying Measures

States report using two main approaches to develop and select new measures. In a few states, internal staff work together to review data specific to their FFS population and determine measures to collect. However, the majority of states interviewed rely on outside expert input in developing new measures. Following are specific state activities:

- **Alabama** collaborates with its Together for Quality Clinical Workgroup, a diverse group including physicians, pharmacists, academia, provider associations, other state agencies, Blue Cross/Blue Shield of Alabama and other stakeholders who select measures and develop measure specifications. In addition, the state works with the provider-based Patient 1st Advisory Council to determine shared savings measures for Patient 1st, Alabama Medicaid's PCCM program. The state's most recent effort includes the formation of the Alabama Healthcare Improvement and Quality Alliance, a group formed to coordinate health care quality improvement activities statewide across purchasers.
- **Colorado** formed the Performance Measurement Advisory Group to recommend new measures. The state developed innovative processes to help its advisory group members select measures, such as creating menus of options and a modified Delphi process to narrow down which measures to use for specific populations. In addition, Colorado included its managed care plans in the measurement selection process.
- **Massachusetts'** process of engaging stakeholders has evolved over time. Originally, the state used a matrix to determine areas of priority, asking stakeholders to rank measures of interest. Currently, Massachusetts uses a rotation of HEDIS measures.
- **Missouri** formed a quality council, including approximately 12 to 15 physicians who meet regularly to determine which measures to use. The quality council members rely on simple criteria to identify relevant measures, such as "Is there a reason to measure this process or outcome?" and "Is it possible to measure it?"
- **North Carolina's** Community Care Networks are highly engaged in quality improvement activities. Each network's medical director serves as a bridge between the local provider community and the statewide program. For example, the providers assist with refining measures that are meaningful in their own efforts to improve quality. Their data is analyzed by the Informatics Center, which reports results back to the network. The Informatics Center, part of a non-profit foundation, serves as an umbrella over the networks and has a data exchange agreement with the state.

Data Collection

In the interviews, states provided details on the process of collecting data to support performance measures. The majority of states use a vendor for measurement data collection.

Role of Vendors

Many states do not have adequate internal staffing resources for data collection and analysis. Thus, most states interviewed use a vendor for some aspect of their performance measurement activity. Specific vendors are listed in Table 1, but only one (Health Services Advisory Group) was interviewed. Frequently, the vendors own the hardware and software that support performance measurement. However, states reported they either have a direct link to those systems (e.g., via a decision-support system) or that vendors share with the state as necessary.

Table 1: Performance Measurement Vendors Used by States

STATE	VENDOR(S)	ROLE OF VENDOR
Alabama	<ul style="list-style-type: none"> ▪ University of South Alabama ▪ University of Alabama at Birmingham ▪ ACS 	Perform analytic support; audit and review data collection methods; incorporate decision-support system into data warehouse.
Colorado	<ul style="list-style-type: none"> ▪ Health Services Advisory Group, Inc. (HSAG) 	Run HEDIS measures using NCQA-certified software, conduct data collection, including record abstraction via subcontracting with medical record firm; submit data to NCQA; conduct HEDIS Compliance Audit™ on its Primary Care Physician Program/FFS populations.
Indiana	<ul style="list-style-type: none"> ▪ Managedcare.com ▪ Milliman 	Run analysis of measures including HEDIS for both managed care and FFS based on data sent by state. In the future, will produce reports and contribute to measure development.
Massachusetts	<ul style="list-style-type: none"> ▪ University of Massachusetts Medical School 	Run claims-based measures; conduct medical record review; drill-down analysis (e.g., to determine which patient characteristics are linked to outcomes).
Missouri	<ul style="list-style-type: none"> ▪ MD Datacor ▪ Thompson Reuters, DataPro ▪ University of Missouri 	Run measures using “semantic extrapolation” (physicians’ dictation reviewed for specific terms/data); validate measures; manage the P4P project.
North Carolina	<ul style="list-style-type: none"> ▪ Area Health Education Center (AHEC) 	Conduct medical record review of randomized sample charts. The vendors review 5 to 30 medical records on-site at approximately 1,500 provider practices (25,000+ charts annually).
Oklahoma	<ul style="list-style-type: none"> ▪ APS Healthcare (as EQRO) 	Assist with conducting an annual diabetes study based on chart review; help conduct an EPSDT chart review.
Pennsylvania	<ul style="list-style-type: none"> ▪ Contracted analytic staff ▪ IPRO (EQRO) ▪ Disease management organization nurses 	Run measures; validate measures and link measures to P4P; review medical records.

Sources of Data

As previously discussed, all of the states and health plans interviewed rely on administrative or claims-level data for HEDIS measures, but only a few rely solely on such data. The majority of interviewed states and health plans supplement administrative data with the following data sources:

- **Medical records.** The majority of states use clinical data abstracted from medical records for quality improvement projects or performance measurement activity. In fact, states explained that they use medical records as a source because administrative data does not typically capture “meaningful” chronic disease measures that can drive quality. For example, in North Carolina, physicians felt that more meaningful measures for asthma quality improvement projects are those captured by clinical data, such as existence of an asthma action plan and indicator of stage two or above asthma severity. A handful of states are exploring innovative ways to extract medical record data. Oklahoma is pilot-testing a new method for gathering clinical data for the HEDIS weight assessment measure, requesting that providers input data into a spreadsheet, which is then submitted to the state. Missouri uses an innovative semantic extrapolation system to find relevant data in dictated chart notes. Missouri is also investigating the possibility of using inpatient facility data sources, including the discharge summary; admit diagnosis; medications prescribed on admit and discharge; diagnosis on discharge; and follow-up data.

Although medical records can provide a detailed account of the care delivered to beneficiaries, record abstraction has limitations. The process is time consuming and expensive. Additionally, the accuracy and reliability of abstracted information vary since they depend on the individual provider documenting the patient’s information. Also, it is not always obvious which provider’s records need to be reviewed, particularly if beneficiaries can go to any provider in FFS. For example, it may be possible that a young woman gets her primary care from her gynecologist. Recently, there has been national interest in using health information technology (HIT) to facilitate collection of medical record data with funding available to practices adopting EHR technology from the American Recovery and Reinvestment Act of 2009 (ARRA). However, very few states expressed confidence that EHR implementation would make a significant difference to their performance measurement processes in the short-term. Despite this, states also recognize the long-term benefits of statewide EHR implementation in facilitating the collection of clinical data and performance measures across health care providers. Some states, such as Pennsylvania, are in the process of developing a Health Information Exchange (HIE) to further coordinate the exchange and sharing of data among providers.

- **Behavioral Risk Factor Surveillance System survey data.** A handful of states partner with their sister health department agencies that collect Behavioral Risk Factor Surveillance System (BRFSS) data annually. The BRFSS is a telephone health surveillance survey that tracks health conditions and risk behaviors. There is substantial overlap between HEDIS and public health measures within the BRFSS. Therefore, states often compare HEDIS specifications with other public health surveillance efforts like the BRFSS. However, states need to address various methodological issues when comparing the data sets.
- **Immunization registry data.** Health information systems that contain immunization information have been developed to enhance and sustain immunization coverage levels. Currently, the HEDIS measure titled Childhood Immunization Status requires health plans to identify the percentage of two-year-old children who have been enrolled for at least a year and received specified immunizations. States and health plans often collect data for this measure from automated immunization records. For example, Colorado uses a “matching process” to access data from the

immunization registry of the Colorado Department of Health. Colorado Medicaid sends a request to the state's Department of Health for eligible Medicaid clients' registry data. Subsequently, the Department of Health sends back relevant patient immunization information. Colorado noted that the use of immunization registry data has helped to make FFS performance measures more accurate and thus comparable to managed care measures. The state saw approximately a 30 percent increase in HEDIS rates when it used the immunization registry.

However, states explained that immunization registry data has limitations. First, the registries are built primarily for childhood immunizations (as opposed to flu and pneumonia for adults). Also, such data does not include immunizations received at community clinics that do not submit insurance claims. In addition, some states like California do not have a statewide immunization registry for FFS beneficiaries. Lastly, although Oklahoma has a statewide immunization registry for FFS beneficiaries, the state does not mandate immunization reporting. Thus, there is low provider penetration (approximately 40 percent), leaving the state with limited immunization data.

- **Lab test results collected directly from labs.** The Health Plan of San Mateo emphasized the importance of using test results directly collected from the lab as a data source for performance measures. When such lab data is obtained administratively, it can provide valuable clinical information in a timelier and more efficient way than extracting medical records. In California, many commercial plans require their vendors like Quest and Labcorp to submit this data feed for HEDIS purposes.
- **Chronic disease and obstetrics assessment forms.** In order to determine the performance of its ACCESS Plus disease management and Healthy Beginnings Plus programs, Pennsylvania developed two tools at the provider-level to track patients seeking care for chronic diseases and obstetrics. Primary care providers and obstetricians receive incentive payments for completing the forms. The forms provide Pennsylvania with valuable clinical information that is particularly relevant to quality improvement projects for disease management and maternal health.
- **Consumer Assessment of Healthcare Providers and Systems.** The Consumer Assessment of Healthcare Providers and Systems, known as CAHPS, consists of a group of surveys designed to assess consumers' health care experiences. For example, CAHPS asks questions such as "were you able to get care when you needed it," "does your doctor communicate well," and "rate your health plan on a scale of 1 to 10." States can use CAHPS to assess consumers' satisfaction with the health care they receive through Medicaid. Recently, CAHPS convened a group of national stakeholders, including disability researchers, consumers, and Medicaid agencies, to help develop a People with Mobility Impairments (PWMI) item set. The new tool incorporates disability-related items to the standard CAHPS survey and thus provides the opportunity to capture health experiences of PWMI.

Limitations and Challenges in Data Collection Reported by States

States reported many challenges in collecting data that would come as no surprise to most managed care plans engaging in such activities. However, other challenges raised in interviews are unique to FFS performance measurement, such as establishing comparable enrollment segments and tracking patients as they lose eligibility. Many states struggle with losing experience data (e.g., utilization history) related to bundled payments to particular care settings, including obstetric providers. In addition, cost-based reimbursement to Federally Qualified Health Centers (FQHCs) and the Indian Health Services (IHS) facilities may challenge states attempting to access data from these providers. Since FQHCs and the IHS facilities receive payment based on costs, these providers may not be required to submit billing

information with specific codes for services provided. Consequently, states sometimes struggle with data collection in these settings that serve populations that typically face significant disparities in health and barriers in access to care.

Many of the states' data collection challenges are based at the provider level. Some states suggested that providers should be given on-the-ground education on how to bill properly to facilitate data collection. In fact, this is an across-the-board issue and many commercial and Medicare payers would also support such provider-level education efforts. Requesting data or medical records from providers can also be a challenge for states. For example, Pennsylvania begins to look for medical record data at the assigned primary care provider's office; however, the state recognizes that beneficiaries can change providers at any time. Consequently, if visits with the PCP of record are missing, Pennsylvania turns to administrative data to locate other providers who may have the missing information. Oklahoma faced provider complaints that the state is asking for data from the wrong physicians. To resolve this matter, Oklahoma now first ensures that the client is tied to that PCP (has had an encounter), then requests data. Oklahoma believes that this has helped improve the response rate for diabetes measures.

Challenges in Data Collection Reported by California Health Plans

During interviews with California health plans, a number of important points were raised about challenges and limitations in data collection for performance measures for FFS populations. Below is a summary of relevant points to consider when developing systems for data collection:

- **Lack of awareness of HEDIS among providers.** One plan stated that many of its providers are not familiar with HEDIS, and do not understand the importance of performance measurement. This is particularly true for providers who predominately serve FFS or have few commercial patients. It is important for states and/or plans to develop provider education activities focused on HEDIS and the importance of performance measures.
- **Barriers in access to medical records.** Health plans reported that they often have difficulty accessing medical records directly from practices. Practices may be reluctant to disseminate such data, citing potential for HIPAA violation as a reason for refusal. States/plans need to provide physicians with an explanation of the legal authority to access records, and may also offer incentives to cooperate with medical record review. Also, they need to be minimally intrusive to the practices.
- **Lack of HIT resources like EHRs to facilitate the data collection process.** Few provider practices have EHRs and even among those who do have such systems, the quality of data input by providers varies significantly.
- **Difficulty linking the provider to the patient encounter.** Providers use multiple National Provider Identification (NPI) numbers in different care settings and so NPIs may differ depending on where the patient received care (e.g., for hospital inpatient, outpatient, and long-term care services). Consequently, it is challenging for health plans to track a unique provider for particular health services. Medi-Cal, like most FFS programs, allows patients to seek care from multiple providers, which poses another issue for plans trying to track their source of care. In sum, California health plans face numerous challenges in linking health care services to particular patient encounters. Some health plans suggested that this issue could be mitigated through attribution logic.
- **Difficulty tracking insurance coverage for Medicaid beneficiaries.** Plans reported difficulty navigating the additional coverage (e.g., other third party coverage) that some beneficiaries have and thus cannot as easily track beneficiaries' encounters. In addition, several plans noted that the state pays for different services through various programs, making it difficult to navigate claims for beneficiaries.
- **Bundled payments pose a challenge for collecting HEDIS measures.** HEDIS rates are negatively affected by bundled payments. In particular, global payments for prenatal care pose a problem in the collection process, because the date of a patient's first visit is not apparent.

Cross-Agency Work

During the process of developing and collecting performance measures, Medicaid agencies create formal and informal partnerships with other state agencies and external organizations. Such partners may include public health departments at state and county levels, long-term care and behavioral health agencies, the office of the insurance commissioner, universities, governor's office staff, health plans, and provider associations. Partners' roles can be as minor as receiving and using data in quality reports or as major as serving as close partners in data collection and analysis.

In particular, several states cited their recent partnership with mental health agencies to improve performance measurement. Recognizing the overlap of mental health services for beneficiaries, several state Medicaid agencies are implementing data sharing across the medical and mental health systems. For example, Colorado saw an opportunity to create performance measures by using the client assessment data collected for beneficiaries receiving behavioral health services. The state's medical and mental health systems are working together to address differences in performance measurement approaches. Indiana's Medicaid agency collaborated with its Department of Mental Health to access assessment data collected at community mental health centers. Currently, Missouri is creating a web-based tool to coordinate outreach between health and mental health systems. These activities demonstrate that states are recognizing the importance of linking medical and mental health services and are collecting performance measures accordingly.

Auditing

Three states interviewed (Colorado, Missouri, and Pennsylvania) use formal auditing processes for their performance measures. All three states contract with vendors for this process generally following NCQA's audit principles (see Table 1 on page 14). Similar to health plan practices, Colorado contracts with separate vendors for data collection and auditing. Pennsylvania contracts with its external auditor, IPRO, to perform source code validation for selected measures. Oklahoma uses the CMS guidelines for EQROs; their vendor validates that the state follows accurate procedures for data collection.

Interviewed states and health plans agreed that auditing affords numerous benefits. First, auditing enhances the credibility of data collected. Colorado explained that it performs audits to satisfy stakeholder questions regarding the validity of data sources. As Pennsylvania notes, auditing and assuring validity is a priority because of its high profile use of its data, including: (1) reporting the measures externally; (2) comparing results against managed care plans; and (3) basing provider rewards/penalties on these measures. In addition to enhancing credibility of data, Colorado explained that auditing gives states the opportunity to uncover fraud and abuse. California health plans also noted that auditing has helped to pinpoint data issues and identify means to improve the data collection process. Auditors have an external perspective and thus can provide states and health plans with early recommendations on how to improve data collection. Lastly, auditors have a powerful voice and can more easily get their foot in the door to collect data on-site.

Public Reporting and Use

Several states make public reports available online to facilitate and promote their use with stakeholders (see Appendix 2 for a list of states' websites). In addition, some states create beneficiary-friendly report cards and share them via enrollment brokers.

States described a range of key stakeholders that use public reports and performance measures. Stakeholders in government — legislators, executive branch staff, and oversight committees — use public reports to inform policy decisions. For example, Alabama said that its public reports help stakeholders identify best practices at the county- or provider-level and thus inform guidelines and recommendations for care. However, Massachusetts cautioned about the limits of using broad public reporting instruments to drive quality improvement projects. The state faced obstacles in achieving quality improvement when it used blunt policy instruments, such as brochures and education materials, to inform providers about how to use performance measures to drive quality improvement.

As a best practice in reporting and use of performance measures, some states go beyond sharing reports at a policymaking level. Several states share performance measures directly with practices, enabling providers to see their own patients' data, thereby identifying areas of need. For example, Alabama provides a dashboard report, which allows providers to identify missed opportunities for delivering evidence-based care (e.g., HbA1C testing for diabetics) at the patient level. In addition to providing reports at the practice level, some states are making data more readily available to patients. Missouri's new patient portal will allow individual patients to review their own data.

In theory, public reports have the potential to inform beneficiaries about provider performance, thus affecting patient choice and subsequently encouraging providers or plans to engage in quality improvement activities to strengthen performance and attract patients. Yet, most interviewees said that the improvement that occurs after the dissemination of public reports actually comes from "healthy competition" among providers. Providers and plans may engage in quality improvement programs to enhance performance measures scores. However, many states said that they have not yet been able to show a direct causal link between public reporting and performance improvement. It may be too soon to see such results. In addition, states said that by highlighting high-performing practices, public reports might mitigate providers' resistance to collecting performance measures.

Pay for Performance

A handful of states have used financial or nonfinancial incentives to encourage use of performance measures and public reports. For example, Pennsylvania uses pay-for-performance (P4P) to attach a financial reward to high-performing providers who care for beneficiaries in the state's ACCESS Plus disease management program. Originally, the state paid providers who met basic standards for participation and processes, a so-called "pay to play" system. Recently, the state shifted toward payment for quality improvement rather than only processes, linking payment to clinical quality and outcomes measures. For example, providers can receive up to \$375 per diabetic member for optimal care management and a quarterly per member per month (PMPM) payment linked to performance measures from the state's PCCM vendor. Missouri uses pre- and post-measures to reward providers for improvements demonstrated over time for their panel of patients. The measures generate a weighted contribution to Missouri's P4P program based on the relative cost of the disease to the Medicaid program. For example, asthma measures contribute 20 percent whereas diabetes measures contribute 34 percent to the overall incentive. In sum, states may need to develop nonfinancial or financial incentive

programs alongside public reporting to encourage performance improvement among providers serving FFS Medicaid beneficiaries.

Analysis and Use of Measures

Several of the states interviewed stratify data according to particular categories, commonly using factors such as age, gender, zip code, county, and type of waiver/aid code. Following are innovative ways that states are stratifying measurement data:

- **Race and ethnicity focus.** In Oklahoma, which has a large Native American population, identifying tribal status is a priority. However data and identifier information for the state's Native Americans is often difficult to track. Frequently, this population seeks care in settings that do not report data. In order to get encounter-level information, Oklahoma obtains Native American claims data, eliminates duplication, and combines the information with the rest of the data collected. This process has helped Oklahoma uncover a significant increase in HEDIS rates for well-child visits.
- **Geography or network focus.** Colorado is tracking geographic variation in utilization and mapping that to a Dartmouth Atlas-type analysis of physician capacity by specialty. The state stratifies data by provider type, service, and county to identify utilization and expenditure trends. Colorado has started looking at both supply- and preference-sensitive care. Also, the state adapted the Dartmouth analysis to fit a Medicaid population (with their frequent diagnoses and procedures) rather than the Medicare end-of-life population relevant to the original Dartmouth model.
- **Provider-level focus.** CalOptima makes stratified data available to provider groups who use the data to analyze barriers to effective care delivery and determine how to improve the delivery of services to various populations. The data is broken down by aid code, race/ethnicity, and age groups.

Quality Improvement Projects

Several states use performance measures to develop and track quality improvement projects for Medicaid FFS populations. Following are brief descriptions of North Carolina and Missouri's approaches. Both states strongly recommended that other states use performance measures to drive quality improvement projects.

- **North Carolina:** North Carolina collects performance measures related to quality improvement efforts that can both improve care and yield an ROI. As previously described, the state conducted an initial study to identify which disease-specific health interventions to pursue, focusing on interventions that can reduce costs and utilization and improve health outcomes. Recently, North Carolina shifted its focus from disease-specific to composite quality improvement projects. For example, the state is focusing on improving care management for SPD populations with comorbidities. North Carolina is also using performance measures to track how well its Community Care networks meet the needs of beneficiaries within its patient-centered medical home model of care. The majority of measures focus on readmissions since North Carolina believes it is important to tie quality improvement to savings.
- **Missouri:** Similarly, Missouri developed quality improvement projects for its Chronic Care Improvement Program, focused on improving the care of patients with chronic diseases. The state contracts with a vendor that identifies and assigns risk scores to patients with chronic diseases. In addition, the state hires nurses and physicians to help providers initiate and sustain

Conclusion: Recommendations for States

This project gathered the experiences of states, plans, and national organizations in developing, collecting, and reporting performance measures for FFS Medicaid beneficiaries. Participating states agreed that the lack of a national system to set standards, maintain performance measures, and provide national benchmarks for FFS Medicaid beneficiaries challenges their ability to monitor the quality of care for people with complex needs. In particular, states expressed interest in collaborating with a national technical assistance entity that would be responsible for managing, updating, and facilitating data exchange of performance measures for FFS Medicaid beneficiaries. Such a national technical assistance entity would be extremely valuable in coordinating state activities to develop and use national standardized measures for quality improvement, care improvement, and to link payment with quality performance.

The new health reform provisions related to the development of national adult measures, modeled after CHIPRA, create significant new opportunities for CMS to support more standardized measures and state technical assistance to facilitate implementation of performance measures. CHIPRA sets the foundation for the process of identifying and developing a core set of child health quality measures for children enrolled in Medicaid and CHIP. Thus, recent federal legislation will provide additional infrastructure to support coordination of state efforts in developing more effective performance measurement approaches for FFS.

Recommendations

In addition to discussing how CMS could support state performance measurement activities for FFS Medicaid beneficiaries, CHCS asked interviewees to provide states with suggestions for developing, collecting, and reporting FFS performance measures. The following summarizes major recommendations.

- ***Involve providers and relevant stakeholders in the process of developing and collecting performance measures.*** California, for example, included stakeholders in many workgroups addressing performance measurement and systems of care for its SPD beneficiaries and those who are dually eligible for both Medicare and Medi-Cal. The participants in these workgroups offered valuable advice, which should be considered in developing a performance measurement system.
- ***Start with a small number of HEDIS measures — but be clear with caveats.*** States that are embarking on performance measurement for their FFS beneficiaries should start with a few HEDIS measures. For example, states can choose measures that health plans are required to report and that are based on administrative data, and adhere as closely as possible to the measurement specifications for comparability. However, for certain subpopulations, states may need to explore other measures that may be more appropriate than HEDIS. The current HEDIS measurement set is not yet comprehensive enough to reflect the needs of beneficiaries with disabilities and complex physical/behavioral health needs. In addition, states should consider stratifying the denominators for HEDIS measures by SSI and TANF eligibility codes to create more comparable measurement between FFS and managed care systems.
- ***Look outside HEDIS for measures of behavioral health service delivery.*** Rates for reported HEDIS behavioral health measures have been low and improvement in these rates has been minimal. In most states, the fragmented delivery system for behavioral health may contribute to this problem. For example, prescription drugs tend to be tracked in the medical system whereas

follow-up after a psychiatric inpatient hospitalization may be located in the mental health data system.

- **Use a multi-faceted measurement set.** States should consider a blended measurement approach that uses both national HEDIS measures as well as clinically actionable measures relevant to the SPD population. Such a strategy will allow states to compare FFS and managed care performance for their broad population as well as assess health care quality for beneficiaries with chronic illnesses and disabilities. A mix of HEDIS and more specialized measures will help states identify opportunities to improve the quality of care and measure the impact of program interventions across the Medicaid population.
- **Set clear and reasonable goals for public reporting.** States should be clear about measurement goals and potential uses of public reporting of measures. For example, it may be unnecessary to report and compare managed care and FFS measures for consumers in areas/groups where choice of health plan is restricted. At the least, stakeholders should be warned not to make these comparisons when results are published, but instead use the results to tailor quality improvement efforts in both programs.
- **Devote resources to auditing measures.** States and health plans found that auditing is a valuable process to ensure accountability and validity. An alternate approach is to use standard practices to conduct an internal audit. Auditing can provide states with the ability to validate and defend data.
- **Consider opportunities to use HIT.** Although some states are skeptical that EHR implementation would make a significant difference to their performance measurement processes in the short term, a few states saw HIT as a major opportunity. States should consider how to leverage new federal HIT funding to develop strategic infrastructure to support performance measurement in the state, such as obtaining lab data or sharing outcomes of care.
- **Value the role of leadership in this process.** An important factor in developing, collecting, and reporting performance measures is state leadership that is committed to measuring quality as a means to improving care. Health plans, providers, and advocates will be reassured by consistent messages about the state's goals for performance measurement.
- **“Just do it!”** States need to jump in and start the work of developing, analyzing, and reporting performance measures for their FFS population. In developing the measures, states will discover what works and what does not work. In addition, public reporting and resulting stakeholder feedback will provide valuable information to help refine the measurement process.

Appendix 1: Participant List for Interviews

STATE INTERVIEWEES	
Alabama	Mary McIntyre (Medical Director); Sharon Moore (Associate Director, Quality Improvement Coordination Program); Theresa Richburg (Director of Quality Improvement Standards Division); Sylisa Perryman (Quality Improvement Coordinator); Susan Jones (Fiscal Agent Liaison); Stephanie Lindsay (Statistical Support Unit)
Colorado	Katie Brookler (Strategic Projects); Gina Robinson (Administrator for the EPSDT program); Lesley Reeder (Performance Management)
Indiana	Glenna Asmus (Manager, Quality and Outcomes)
Massachusetts	Ann Lawthers (Director of Quality Improvement)
Missouri	George Oestreich (Medical Director); DJ Johnson (Medicaid Specialist); Jayne Zemmer (Program Manager)
New York	Joseph Anarella (Deputy Director); Jacqueline Matson (Director, Bureau of Quality Measurement and Improvement)
North Carolina	Denise Levis-Hewson (Director of Clinical Programs and Quality Improvement); Annette DuBard (Director of Informatics, Quality, and Evaluation); Tammy Panzera (Data Analyst)
Oklahoma	Patricia Johnson (Director of Quality Assurance); Lise DeShea (Statistician, Quality Assurance and Improvement Division)
Pennsylvania	David Kelley, MD (Chief Medical Officer); Jennifer Basom (Director, Division of Quality Management); Scott Flinchbaugh (Project Manager, Clinical Quality Improvement, ACCESS Plus); Sherry Logan; Karen Tuzza
CALIFORNIA HEALTH PLANS/COHS AND ORGANIZATION INTERVIEWEES	
Accelerating Quality Improvement through Collaboration (AQIC)	Margie Powers (Health Care Consultant)
CalOptima	Linda Lee (Director of Medical Data Management)
Health Plan of San Mateo	Mary Giammona (Medical Director); Denise Gurgens (Quality Assessment and Improvement Manager); Vicky Shih (Statistician)
Health Services Advisory Group (HSAG)	Peggy Ketterer (Executive Director, EQRO Services); Mary Fermazin (Vice President, Health Policy & Quality Measurement)
Partnership Health Plan of California	Cindi Ardans (Quality Monitoring and Improvement Manager); Trina Buehrer (Quality Improvement Project Coordinator)
NATIONAL ORGANIZATION INTERVIEWEES	
Centers for Medicare & Medicaid Services (CMS)	Barbara Dailey (Director); John Young (Health Insurance Specialist)
National Academy for State Health Policy (NASHP)	Catherine Hess (Senior Program Director); Diane Justice (Senior Program Director); Sarah DeLone (Program Director); Elizabeth Osius (Policy Analyst)
National Committee for Quality Assurance (NCQA)	Sarah Scholle (Assistant Vice President, Research and Analysis); Natalie Davis (Health Care Analyst, Performance Measurement)
National Partnership for Women and Families	Lee Partridge (Senior Health Policy Advisor)

Appendix 2: Publicly Reported Measures for Medicaid Programs

STATE PROGRAM(S)	WHERE TO FIND THE DATA	COLLECTED AND/OR REPORTED MEASURES
<p>Alabama Patient 1st Program — Medicaid Primary Care Case Management (PCCM)</p> <p>Together for Quality (TFQ)-Alabama Medicaid Transformation Grant Program</p>	<p>http://www.medicaid.alabama.gov/documents/Program-Dental/3-A-6_DENTAL_Stats_FY09_4-9-10.pdf</p> <p>http://www.medicaid.alabama.gov/documents/Program-Pt1st/3-H_1c_Sample_Profiler_7-09.pdf</p> <p>http://www.medicaid.alabama.gov/Transformation/Pilot_Co_Diabetic_Measures.aspx</p> <p>http://www.medicaid.alabama.gov/Transformation/Pilot_Counties_Asthma_Measures.aspx</p>	<p>Alabama collects data for its Medicaid beneficiaries, currently using 2009 HEDIS and HEDIS-like specifications. The current measures collected include: Asthma; Diabetes; Maternity Care (Prenatal and Perinatal); Dental; Immunizations; Well-Child Care; Experiences of Care; Access And Availability; Utilization of Services; such as Generic Prescription Utilization; Emergency Room; and Inpatient Hospitalization.</p> <p>Recommendations for 2010 incorporate the collection of additional measures, including, but not limited to: Colorectal Cancer Screening; Chlamydia Screening; Cesarean Rate; Pharyngitis Appropriate Testing; and Mental Health Follow-up.</p>
<p>Colorado Fee-For-Service (FFS); Primary Care Physician Program, (PCPP); CHP Plus</p>	<p>www.chcpf.state.co.us Click on Health Outcomes Quality Management</p>	<p>2009 HEDIS includes Pediatric Measures (Well Child Visits, Immunizations, Appropriate Treatment For URI); Access to Care; Utilization of Services; Women’s Health (Breast Cancer Screening, Pregnancy-Related); Chronic Disease (Diabetes, Asthma, Cardiovascular Disease, Obesity, Management of Medications); Ambulatory Care (Outpatient, ED); and Inpatient Utilization (Inpatient, Medicine, Surgery, Maternity).</p> <p>In 2010, Colorado is considering adding HEDIS-like measures for children, including: Adolescent Counseling; Depression Management; Prevention Quality Indicators (PQIs) in Pediatrics; and Behavioral Risk Factors. In addition, for the SPD population, Colorado is considering adding percentage of behavioral health clients who fail to refill medications.</p> <p>Colorado also collects data on health status measures (BRFSS, PRAMS and NSCH), admissions for ambulatory care sensitive conditions (PQI for all clients), readmissions; behavioral health quality, utilization and functional status (behavioral health is a carve-out), some nursing home performance in a P4P arrangement and has started looking at supply sensitive and preference sensitive data.</p>

STATE PROGRAM(S)	WHERE TO FIND THE DATA	COLLECTED AND/OR REPORTED MEASURES
<p>Indiana Care Select — Care Management Organizations</p>	<p>N/A</p>	<p>Indiana implemented a performance-withholding program (pay-for-performance) with a set of performance measures and targets that providers must meet in order to receive incentive payments. Measures include: PQI for Diabetes Short-Term Complications, Bacterial Pneumonia Admission Rate, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease; ER Utilization for All Conditions; Follow-Up After Hospitalization for Mental Illness; Anti-Depressant Management Acute Phase; Annual Dental Visit; Breast Cancer Screening; Cholesterol Screening; Well Child Visits; ER Bounce Back; Inpatient Bounce Back; Asthma Medications; and Care Coordination (Assessments, Stratifications, Care Plans).</p> <p>Beginning in 2010, Indiana is aiming to use health risk screeners for the Care Select population. The screeners will be used for understanding health information about the population in Care Select.</p>
<p>Massachusetts Medicaid Primary Care Clinician Plan (PCC)</p>	<p>http://www.mass.gov/Eeohhs2/docs/masshealth/research/hedis_2008.pdf</p>	<p>Massachusetts conducts an assessment of MassHealth managed care organizations to identify health plan performance and identify opportunities for quality improvement for MassHealth beneficiaries. The MassHealth Managed Care HEDIS 2008 Report includes the following measures: Childhood Immunization; Well-Child and Well-Care Visits; Children and Adolescent’s Access to Primary Care Physicians; Use of Appropriate Medications for People With Asthma; Antidepressant Medication Management; Follow-Up After Hospitalization for Mental Illness; Appropriate Treatment For Children With Upper Respiratory Syndrome; and Mental Health Utilization.</p>
<p>Missouri Chronic Care Improvement Program (CCIP)</p>	<p>N/A</p>	<p>Currently, there are 12 measures for the CCIP, focusing on chronic care activities for diabetes, asthma, cardiovascular disease and other conditions among beneficiaries. Missouri has found it difficult to create a comparable measure between FFS and managed care due to differences in the populations. Thus, the state is beginning to develop more HEDIS-like measures for comparison between FFS and managed care. Currently, there are four HEDIS-like measures.</p> <p>Missouri created a web-based tool (APS CareConnection) for the CCIP. The web-based tool facilitates performance measurement and reporting since providers can view and input performance measure data more easily.</p> <p>To encourage physicians to use the technology to input performance measures, the state linked pay-for-performance to use of the tool. Missouri implemented a pay-for-performance program with a set of performance measures and targets that providers must meet in order to receive incentive payments.</p>

STATE PROGRAM(S)	WHERE TO FIND THE DATA	COLLECTED AND/OR REPORTED MEASURES
<p>New York Managed Care Program</p>	<p>www.health.state.ny.us/health_care/managed_care/reports/eqarr/2008</p>	<p>New York developed eQARR (Quality Assurance Reporting Requirements) to enable consumers to evaluate the quality of health care services provided by New York State's managed care plans. QARR measures are largely adopted from HEDIS with New York State-specific measures added to address public health issues of particular importance in New York. QARR also includes information collected from the national consumer satisfaction survey, CAHPS. The perinatal health measures are calculated by the New York State Department of Health, using birth data submitted by the health plans and the Department's Vital Statistics file. Measures include the following: Childhood Immunization; Lead Testing; Well-Child and Preventive Care Visits; Annual Dental Visit; Appropriate Treatment for Upper Respiratory Infection (URI), Appropriate Testing for Pharyngitis; Use of Appropriate Medications for People with Asthma Ages 5-17; Follow-Up Care for Children Prescribed ADHD Medication; Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening; Timeliness of Prenatal Care; Postpartum Care; Frequency of Ongoing Prenatal Care; Perinatal Health (Risk-Adjusted Low Birthweight (LBW); Prenatal Care in the First Trimester; LBW Births at Level II/III/IV Facilities); Colon Cancer Screening; Annual Dental Visit; Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis; Smoking Cessation; Flu Shot for Adults; Controlling High Blood Pressure; Cholesterol Management for Patients with Cardiovascular Conditions; Persistence of Beta Blocker Use; Use of Appropriate Medications for People with Asthma Ages 18-56; Use of Appropriate Asthma Medications; Use of Spirometry Testing in the Assessment and Diagnosis of COPD; Pharmacotherapy Management of COPD Exacerbation; Comprehensive Diabetes Care; Drug Therapy for Rheumatoid Arthritis; Annual Monitoring for Patients on Persistent Medications; Antidepressant Medication Management; and Follow-up After Hospitalization for Mental Illness.</p> <p>NY conducted a study in 2008 comparing FFS and managed care performance measures of children and adolescents for outpatient use, well-child visits and dental utilization. Analyses include percent of population captured by eligibility criteria and Clinical Risk Group comparison.</p>

STATE PROGRAM(S)	WHERE TO FIND THE DATA	COLLECTED AND/OR REPORTED MEASURES
<p>North Carolina FFS and PCCM</p>	<p>http://www.ncdhhs.gov/dma/quality/</p>	<p>In North Carolina, Medicaid beneficiaries are eligible for chart review on the basis of asthma, diabetes, ischemic vascular disease, and heart failure. Chart review measures pertain to: Appropriate Asthma Management; Diabetes Glycemic Control and Foot Care; Management of Blood Pressure, Cholesterol, and Tobacco Use; Appropriate Aspirin Use; and Assessment of LV Function In Heart Failure.</p> <p>North Carolina uses an additional set of measures for Medicaid beneficiaries, derived from Medicaid claims data, pertaining to: Medication Therapy for Asthma, Heart Failure, And Post-MI Patients; Adult Preventive Services (Breast, Cervical, And Colorectal Cancer Screening); and Pediatric Preventive Services (Dental Care and Well Child Exams).</p>
<p>Oklahoma SoonerCare (PCCM program)</p>	<p>www.ohca.state.ok.us Click on Research and Statistics, then Reports, and then Minding Our Ps and Qs for annual compendium of quality studies, or on selected studies listed.</p>	<p>Oklahoma uses HEDIS measures to track annual performance on dimensions of care and service for SoonerCare beneficiaries. The state uses the following HEDIS measures: Annual Dental Visit; Breast/Cervical Cancer Screening; Child Health Checks; Children’s Access to PCP; Adult Access to Preventive/Ambulatory Health Services; Comprehensive Diabetes Care; Appropriate Medications for the Treatment of Asthma; Appropriate Treatment for Children with Upper Respiratory Infection; Appropriate Testing for Children with Pharyngitis; Lead Screening in Children; and Cholesterol Management for Patients with Cardiovascular Conditions.</p>

STATE PROGRAM(S)	WHERE TO FIND THE DATA	COLLECTED AND/OR REPORTED MEASURES
<p>Pennsylvania HealthChoices (managed care) and ACCESS Plus (PCCM)</p>	<p>http://www.dpw.state.pa.us/PubsFormsReports/MedicalAssistanceDocuments/003674902.htm www.dpw.state.pa.us/omap/hcmc/omaphcmci.asp Click on External Quality Review Reports.</p>	<p>Pennsylvania conducts an annual external quality review of the services provided by contracted Medicaid MCOs participating in the state’s HealthChoices Program. The state collects data on the quality of health care services that MCOs provide to Medicaid recipients, using the following HEDIS measures: Monitoring for Obesity; Childhood Immunizations; Lead Screening in Children; Appropriate Testing for Children with Pharyngitis; Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis; Appropriate Treatment for Children with Upper Respiratory Infection; Breast/Cervical Cancer Screening, Chlamydia Screening in Women; Controlling High Blood Pressure; Beta-blocker Treatment After a Heart Attack; Cholesterol Management for Patients with Cardiovascular Conditions; Comprehensive Diabetes Care; Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis; Annual Monitoring for Patients on Persistent Medications; Use of Appropriate Medications for People with Asthma; Children’s Access to PCP; Adult Access to Preventive/Ambulatory Health Services; Perinatal and Postpartum Care; Annual Dental Visits; Frequency of Ongoing Prenatal Care; Frequency of Well Care Visits (Child/Adolescent); Frequency of Selected Procedures (10 specific procedures); Inpatient Utilization; Ambulatory care utilization; Drug Utilization; and Antibiotic Utilization (including specific drug classes). Pennsylvania also collects data for Medicaid beneficiaries enrolled in ACCESS Plus, an Enhanced Primary Care Case Management (EPCCM) medical home and disease management program. HEDIS-like data are collected to compare the quality of care and levels of preventative care provided.</p> <p>In 2005, Pennsylvania implemented a P4P program for HealthChoices, targeted to reward managed care plans to improve 10 defined HEDIS measures. Pennsylvania also developed the Access Plus P4P program that rewards PCPs for quality of care and participation in disease management, using patient self-reports and claims data indicating physician prescribing of “key medications” that have been shown to reduce disease exacerbations or improve clinical outcomes for particular chronic conditions.</p>