CHCS Center for Health Care Strategies, Inc.

Policy Brief

Leveraging the Medicaid Primary Care Rate Increase: The Role of Performance Measurement

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The Affordable Care Act (ACA) created numerous opportunities to improve primary care, one of which is an increase in provider reimbursement. In 2013 and 2014, Medicaid is required to reimburse primary care providers (PCPs) at parity with Medicare rates—a "bump" that is funded 100 percent by the federal government. This provision will infuse up to $8.3 billion into the historically underfunded Medicaid primary care system. These additional resources will enable Medicaid to potentially stabilize the primary care workforce and expand access while helping practices make investments to improve access to and quality of care.

Understanding the effects of increased reimbursement on access, utilization, and quality can help states and policymakers in determining whether to sustain the "bump" beyond 2014, when Medicaid coverage will expand to up to 80 million Americans.[1] This brief identifies how Medicaid agencies can use performance measurement to assess the impact of the increase, and to determine whether to sustain the "bump" beyond the critical 2014 threshold. It details potential access, utilization, and quality measures that can augment existing state measurement activities and outlines considerations for states in incorporating new measures.

IN BRIEF

With the passage of the Affordable Care Act (ACA), Medicaid will expand significantly starting in 2014 and cover an additional 16-20 million people. This unprecedented increase in beneficiaries will likely strain Medicaid's already overburdened primary care system.

Through the ACA, in 2013 and 2014, Medicaid is required to reimburse primary care providers at parity with Medicare rates—a "bump" that is funded 100 percent by the federal government. Measuring the impact of the increase will be critical to helping states and policymakers understand the effects of increased reimbursement on access, utilization, and quality, and to making a case for sustaining the increase beyond 2014. This brief outlines how Medicaid agencies can use performance measurement to assess the impact of the rate increase.

Background

Historically, Medicaid has been the lowest payer for primary care services relative to Medicare and commercial insurance, paying just 66 percent of Medicare rates on average.[2] More recently, states have been forced to reduce Medicaid expenditures through rate, benefits, and service cuts to manage increasingly burdensome budget deficits. Section 1202 of the Health Care and Education Reconciliation Act, passed alongside the ACA, puts Medicaid on firmer footing in its support of PCPs, stating that physicians in family medicine, internal medicine, or pediatrics will be reimbursed at Medicare levels for a specific set of evaluation and management (E&M) codes for two years.

Leveraging the "Bump" for Increased Access

States can leverage the rate increase to support and expand the primary care workforce and increase access to services for current and new beneficiaries. Table 1 highlights state-level percentage increases from 2008 Medicaid FFS primary care rates to 2008 Medicare FFS primary care rates, as well as the number of new Medicaid beneficiaries associated with the Medicaid expansion. Though there is significant state-by-state variation, this data speaks clearly to the need for states to strengthen the primary care workforce.

The need to expand the Medicaid primary care network is pressing: in 2008, only 42 percent of primary care providers in the United States reported accepting new patients with Medicaid, compared to 61 percent and

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Table 1: State-by-State Comparison of PCP Rate Increase and Medicaid Population Expansion as a Result of Health Reform		
	% Change in PCP Rates through Section 1202[3]*	% Increase in Medicaid Population through ACA[4]
US	**51.5%**	**27.4%**
Alabama	28.2%	36.9%
Alaska	0%**	38.5%
Arizona	3.1%	7.7%
Arkansas	28.2%	27.9%
California	112.8%	20.1%
Colorado	14.9%	47.7%
Connecticut	28.2%	20.1%
Delaware	0%**	6.7%
Washington, D.C.	112.8%	16.1%
Florida	81.8%	34.7%
Georgia	16.3%	40.4%
Hawaii	56.3%	38.0%
Idaho	0%**	39.4%
Illinois	75.4%	25.8%
Indiana	63.9%	29.4%
Iowa	12.4%	25.3%
Kansas	6.4%	42.0%
Kentucky	25.0%	37.3%
Louisiana	11.1%	32.4%
Maine	88.7%	11.8%
Maryland	22.0%	32.4%
Massachusetts	28.2%	2.0%
Michigan	69.5%	30.2%
Minnesota	72.4%	32.9%
Mississippi	19.0%	41.2%
Missouri	53.8%	29.8%
Montana	4.2%	54.5%
Nebraska	22.0%	36.2%
Nevada	7.5%	61.7%
New Hampshire	49.3%	38.8%
New Jersey	143.9%	38.1%
New Mexico	2.0%	28.3%
New York	177.8%	6.0%
North Carolina	5.3%	38.2%
North Dakota	0%**	44.0%
Ohio	51.5%	31.9%
Oklahoma	0%**	51.2%
Oregon	28.2%	60.6%
Pennsylvania	61.3%	21.7%
Rhode Island	177.8%	20.0%
South Carolina	16.3%	38.4%
South Dakota	17.6%	25.9%
Tennessee	N/A	20.9%
Texas	47.1%	45.5%
Utah	31.6%	56.1%
Vermont	9.9%	2.8%
Virginia	13.6%	41.8%
Washington	8.7%	25.2%
West Virginia	29.9%	29.5%
Wisconsin	49.3%	20.8%
Wyoming	0%**	40.0%

* Percent change in PCP Rates from 2008 Medicaid-to-Medicare Fee Index (from Zuckerman et al., 2009) to a Medicaid-to-Medicare Fee Index of 1.00.

**Medicaid primary care rates in this state surpass Medicare primary care rates.

84 percent of providers accepting Medicare and private insurance, respectively.[5] Using the incentive of the primary care rate increase, states can work with medical societies to encourage non-participating physicians to accept Medicaid. For physicians already in the Medicaid network, the additional revenue of the "bump" can make it financially viable to increase their Medicaid panel size and potentially expand office hours and staff availability.

The ability to expand access will vary by state. One analysis estimates that states with low Medicaid-to-Medicare reimbursement ratios could see a roughly 24 percent increase in Medicaid PCP supply as a result of the rate increase, while states with high ratios are estimated to see a 10 percent increase in PCPs.[5] States with a relatively small number of PCPs accepting Medicaid patients generally already have Medicaid reimbursement rates close to or exceeding Medicare rates.[5]

Leveraging the "Bump" to Improve Utilization and Quality

PCPs can use the new revenue to invest in advanced primary care delivery models such as patient-centered medical homes and health homes. Practices can use the funds to hire a care manager or finance information technology to support clinical decision-making and population management. If the increase enhances patients' ability to access primary care and enables PCPs to invest in service delivery, both utilization and quality of care may improve over time. For example, increased access to primary care services may lower rates of inappropriate emergency department utilization or hospital readmissions. New investments may also boost the quality of care, particularly in states with low reimbursement where the influx of new revenue will be most meaningful to PCPs.

Expanding Performance Measurement to Monitor the PCP Rate Increase

Enhancing existing measurement activities to include access, quality, and utilization metrics relevant to the "bump" will be critical to measuring its impact and potentially sustaining it. States currently rely on several approaches to collect such data, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Healthcare Effectiveness Data and Information Set (HEDIS), workforce surveys, and other mechanisms.

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Recognizing that it is not easy for states to expand measurement in an environment of constrained resources, the next two sections describe specific access and utilization metrics that states can consider incorporating into existing performance measurement activities in order to measure the impact of the increase. The third section describes approaches that states can take to strengthen quality data collection efforts, particularly across programs and payers. The last section highlights key considerations to inform states as they move forward to develop new measurement strategies.

Measuring Changes in Access to Primary Care

Following is an inventory of access metrics available to states for determining patient access to primary care. States are encouraged to select the subset that reflects aspects of metrics that are most relevant to their market and are easiest to implement.

Access Metrics from MMIS Data

States have readily available data sources that can be used to measure patient access to primary care services, such as:

- Number of E&M visits with a PCP, per beneficiary (by age bands);
- Patient-to-PCP ratio (broken down by physician and physician extenders); and
- Ratio of PCPs accepting new Medicaid patients to the total number of PCPs in the state.

These metrics are accessible to states through MMIS, so the cost of collecting and analyzing them may be low relative to other patient access data collection approaches. However, because PCP-to-patient ratios change over time, many states have found them difficult to keep up to date.

Access Metrics from Managed Care Contracts

Medicaid managed care contracts regularly include provisions regarding availability of primary care services. For example, contracts often require managed care organizations to:

- Ensure a reasonable provider-to-patient ratio (e.g., that a caseload for an individual provider does not exceed 1,500 of its managed care members);
- Minimize scheduled wait times to see primary care providers (e.g., that a patient wait no more than one month for a well-care visit);
- Ensure that appointments are conducted on time or within a specific time frame (e.g., that a patient wait no longer than 45 minutes in the waiting room); and
- Minimize travel times and distances for patients.

Because such data are often difficult for states to collect across their entire population, states can require their managed care plans to provide standardized data on these metrics, both statewide and by regions of interest.

State Physician Workforce Surveys

Many states conduct physician workforce surveys to evaluate the long-term strength of their physician workforce relative to projected statewide health care needs. These surveys often ask questions that examine issues of access and physician availability, including:

- Percent of patient panel insured by Medicaid;
- Whether physicians accept new Medicaid patients;
- Time to appointment for a PCP or pediatrician visit for existing patients;
- Time to appointment for a PCP or pediatrician visit for new patients;
- Average number of patients seen each week; and
- Number of hours of direct patient care per week.

These surveys provide a ready-made opportunity for states to collect data and evaluate trends in primary care access metrics over time. States can work with survey administrators — universities, state medical societies, or other organizations — to add access questions of relevance to Medicaid.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Access Measures

The CHIPRA core set includes both direct access measures and measures that address timeliness of well-child visits, which may correlate with access to care. These measures are:

- Access to PCPs, by age and total; and
- Well-child visits (within the first 15 months and in the third, fourth, fifth and sixth years of life).

CAHPS Access Measures

The supplemental CAHPS® Clinician and Group (CG-CAHPS) Survey

includes questions that address the access patients have to their PCPs, providing important information for evaluating the availability of services. The CG-CAHPS survey includes:

- Appointment availability;
- Scheduling wait times for routine and urgent care;
- After-hours communication access;
- Office waiting room wait times; and
- Comparable questions for the pediatric population.

In 2011, a Patient Centered Medical Home (PCMH) survey was added to the CAHPS collection of surveys,[6] and is slated to become a part of the National Committee for Quality Assurance's (NCQA) updated specifications for its PCMH program. This PCMH survey includes specific access and communication metrics such as:

- Whether a provider's office provided information about how to access care during evenings, weekends, and holidays;
- Whether a patient was able to get needed care during evenings, weekends, and holidays; and
- Whether a provider's office reminded the patient between visits about tests, treatment or appointments.

Measuring Changes in Utilization of Health Care Services

States benefit from relatively easy access to a number of utilization metrics. For example, claims data can often provide insight into Medicaid utilization patterns linked to specific practice sites. States also have access to a range of utilization metrics developed by national organizations (see Table 2). States are encouraged to select utilization measures that are likely to be impacted by increased access and are easiest for Medicaid to collect. Utilization measures that focus on inpatient and emergency room admissions, as well as on avoidable readmissions, may prove the most sensitive to changes in access to and availability of primary care services.

Table 2: **Potential Utilization Metrics**

Measure	Source
30-day All-Cause Risk Standardized Readmission Rate	Readmissions (United Health Group)
Inpatient Utilization—General Hospital/Acute Care	HEDIS® (NCQA)
Ambulatory Care: Emergency Department Visits	HEDIS® (NCQA)
Ambulatory Care: Outpatient Visits	HEDIS® (NCQA)
PICU Unplanned Readmission Rate	Readmissions (NACHRI)
Review of Unplanned PICU Readmissions	Readmissions (NACHRI)
Low Birth Weight Rate	Prevention Quality Indicators (AHRQ)[7]
Asthma	Relative Resource Use (NCQA)[8]
Asthma Admission Rate	Pediatric Quality Indicators (AHRQ)[9]
Asthma in Younger Adults Admission Rate	Prevention Quality Indicators (AHRQ)
Cardiovascular Conditions	Relative Resource Use (NCQA)
Hypertension	Relative Resource Use (NCQA)
Hypertension Admission Rate	Prevention Quality Indicators (AHRQ)
COPD	Relative Resource Use (NCQA)
Diabetes	Relative Resource Use (NCQA)
Uncontrolled Diabetes Admission Rate	Prevention Quality Indicators (AHRQ)
Diabetes Short-term Complications Admission Rate	Prevention Quality Indicators (AHRQ)
Diabetes Short-term Complications Admission Rate	Pediatric Quality Indicators (AHRQ)
Diabetes Long-term Complications Admission Rate	Prevention Quality Indicators (AHRQ)

States can use this opportunity to further their understanding of what measurement activities are currently underway, identify where measurement programs overlap, and determine ways to streamline, align, and improve Medicaid monitoring strategies.

Despite the availability of these potential utilization metrics, determining the exact impact of the "bump" on utilization may prove difficult. The PCP payment increase is not the only provision of health reform that would impact access to care and utilization of services for Medicaid beneficiaries; the health home care management and coordination services provided for in Section 2703 of the ACA, for example, are also expected to improve access to care. Isolating the impact of these various provisions and programs is challenging in terms of being able to attribute changes solely to one program or another. States may also elicit evaluation assistance from local universities to develop a more robust assessment of the "bump" as part of their overall health care reform research agenda.

Strengthening Quality Performance Measurement Across the Health System

While the increased reimbursement may have a long-term rather than a short-term impact on quality, states can use this opportunity to further their understanding of what measurement activities are currently underway, identify where measurement programs overlap, and determine ways to streamline, align, and improve Medicaid monitoring strategies. Many of the quality reporting metrics that are part of the ACA and CHIPRA, as well as the American Recovery and Reinvestment Act of 2009, are highly relevant to Medicaid populations. With these measures, Medicaid can assess both health system and physician organization quality performance.

States can also seize this opportunity to align performance measurement activities with Medicare and commercial markets. By doing so, states can assist physicians who are increasingly subject to a complex array of overlapping quality measures from multiple national programs (see Appendix A for Medicaid-relevant metrics across multiple programs). Aligning measures across payers can also enhance the level of physician accountability for performance. Strategically leveraging federal requirements with existing state and local initiatives will enable Medicaid to develop a more streamlined measurement approach.

States tend to publish quality and consumer experience data at the plan level and do not always report statewide or physician organization-level data, which are critical to understanding and improving health system performance. In the context of the rate increase, states can build on these measurement programs and develop processes and systems to collect and share data at the physician organization level.

Guidance to States for Expanding Performance Measurement

Through the primary care rate increase, states have a new opportunity to leverage Medicaid's purchasing power to drive quality improvements and accountability for the population it serves. Following are core considerations to guide states in developing measurement strategies to assess potential gains associated with the increase:

1. **Align with existing and future measurement efforts**. Individual states and physician organizations participate in multiple Medicaid quality improvement initiatives, many of which include a performance measures component. For example, states developing Medicaid health homes will need to collect metrics, many of which overlap with the Medicaid Adult and CHIPRA core measures and Meaningful Use measures. As noted earlier, states can seek to create efficiencies by identifying and prioritizing measures included in multiple initiatives and aligning data

collection and reporting (see Appendix A for an inventory of Medicaid-related performance measures). States interested in developing physician-level reporting should assess existing statewide or health plan measurement efforts and estimate the resources needed to calculate those measures at the physician organization level.

2. **Participate in multi-payer initiatives.**
Many multi-payer initiatives focused on improving health care quality exist in communities across the United States. Medicaid can benefit from participating in these activities, since the larger volume of data increases the number of physician organizations that can be reliably measured. Such multi-payer reporting efforts create the potential for increased efficiencies, particularly if claims-level data is being aggregated and assessed. Physician organizations are more willing to engage in performance measurement activities when results reflect performance across their entire patient panel.

3. **Partner with MCOs.**
States with high managed care penetration and a shortage of analytic resources can consider using MCO contracts to support standardized primary care provider measurement strategies. MCOs typically report on plan-level HEDIS and CAHPS metrics and can build on these efforts to establish a statewide performance snapshot. States can potentially aggregate physician data across MCOs to create a full picture of performance.

4. **Select a core set of metrics.**
Recognizing the resources needed to expand measurement activities, states can initially choose a small set of strategically chosen metrics. Given the short time span and the potentially limited impact of the rate increase, states should select measures they think are most likely to be impacted. At the same time, states may want to eliminate measures that may be positively impacted through other state efforts such as medical homes, health homes, and/or accountable care organizations.

5. **Start early.**
Expanding performance measurement programs to capture relevant access, utilization and quality metrics may necessitate additional programming and analytic efforts from states. States should begin to develop the systems and processes necessary to capture any additional metrics by the end of 2013, when they must evaluate whether or not to continue the increase without federal funding assistance. An early commitment to these measurement efforts will help states conduct a timely and thoughtful assessment.

6. **Engage physicians and physician organizations.**
Obtaining physician buy-in is a key step toward ensuring that performance measures accurately reflect the care that providers are able to deliver. Physicians can help infuse critical reality checks into what is or is not working at the ground level in measuring improvements in care delivery for the Medicaid population.

7. **Involve patients.**
Finally, given that the rate increase is designed to improve patient access to primary care, it is essential to understand what that looks like from the patient's perspective. Understanding what factors, such as PCP availability, might increase patients' use of primary care, and how their experience changes during the rate increase, will provide an important context for interpreting the measurement results. In addition

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to measuring patient wait time for appointments, wait times to next available appointment, and physician access via e-mail, states should also consider pre- and post-surveys of patients' perspectives on access to primary care services.

Conclusion

The Medicaid primary care rate increase mandated under the ACA presents states with the impetus to strengthen existing performance measurement activities. Pursuing this opportunity will support state efforts to develop a primary care network that offers greater access to care and improved health care quality and efficiency. Monitoring the impact of the increase will help states understand the relationship between reimbursement and key aspects of primary care, identify ways to strategically sustain the increase beyond 2014, and continue to make cost-effective investments in primary care.

Finally, it is important to note that the imperative to measure the impact of the increase takes place within the broader context of increased Medicaid purchasing power. Under health reform, Medicaid will serve just over one-quarter of the U.S. population, making it the nation's largest purchaser of health care.[10] Coupled with the rate increase, this shift puts states on par with Medicare, increasing Medicaid's purchasing power significantly and creating an important lever to advance the delivery of high-quality primary care across the nation through greater accountability.[11]

Leveraging the Medicaid Primary Care Rate Increase
This brief is a product of *Leveraging the Medicaid Primary Care Rate Increase*, a Center for Health Care Strategies (CHCS) initiative made possible by The Commonwealth Fund. Through this initiative, CHCS is working with state Medicaid agencies and health plans in six states, as well as with the Centers for Medicare & Medicaid Services, on the implementation of the Medicaid primary care rate increase mandated under health care reform. In addition to this brief, CHCS will develop recommendations on how states can use the increased reimbursement as a platform to create more effective incentives for advanced primary care delivery than are available in fee-for-service.

APPENDIX A: **Crosswalk of Key Medicaid Performance Measures That Appear In Multiple National Initiatives**

Measure/Type	Developer	Meaningful Use EHR Incentive Program[12]	2011 Physician Quality Reporting System[13]	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults[14]	CHIPRA Initial Core Set Measures[15]	Proposed Health Homes Core Quality Measures	NOTES
Utilization							
Ambulatory Care: Emergency Department Visits	NCQA/HEDIS				x		
Use of Imaging Studies for Low Back Pain	NCQA	x					
Diabetes, Short-Term Complications Admission Rate (PQI)	AHRQ			x			
Adult Asthma Admission Rate (PQI)	AHRQ			x			
Quality							
Childhood Immunization Status	NCQA/HEDIS	x			x		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA/HEDIS	x			x		
Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	x	x		x		
Adult Weight Screening and Follow-up	CMS	x	x	x		x	
Flu Shots for Adults Ages 50-64	NCQA	x	x	x			Measure specifications are not exactly consonant
Preventive Care and Screening: Colorectal Cancer Screening	NCQA	x	x				
Breast Cancer Screening	NCQA	x	x	x			
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	x	x	x			

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Cervical Cancer Screening	NCQA	x		x			
Chlamydia Screening	NCQA/HEDIS	x		x	x		Age ranges differ
Screening for Clinical Depression and Follow-Up Plan	CMS		x	x		x	
Follow-up after Hospitalization for Mental Illness	NCQA/HEDIS			x	x	x	Age ranges differ
Antidepressant Medication Management	NCQA	x		x			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	x		x		x	
Diabetes: Hemoglobin A1C	NCQA		x	x	x		Age ranges differ
Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA	x	x				
Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA	x	x	x			
High Blood Pressure Control in Diabetes Mellitus	NCQA	x	x				
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	AMA-PCPI*	x	x				
Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	AMA-PCPI	x	x				
Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	AMA-PCPI	x	x				
Diabetes Mellitus: Foot Exam	NCQA	x	x				

Measure/Type	Developer	Meaningful Use EHR Incentive Program[12]	2011 Physician Quality Reporting System[13]	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults[14]	CHIPRA Initial Core Set Measures[15]	Proposed Health Homes Core Quality Measures	NOTES
Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA	x	x				
Asthma: Pharmacologic Therapy	AMA-PCPI	x	x				
Asthma Assessment	AMA-PCPI	x	x				
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol	AMA-PCPI	x	x				
Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI	x	x				
Comprehensive Ischemic Vascular Disease Care: Complete Lipid Profile and LDL-C Control Rates	NCQA	x	x				
Ischemic Vascular Disease (IVD): Blood Pressure Management Control	NCQA	x	x				
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NCQA	x	x				
Beta-Blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)	AMA-PCPI	x	x				
Controlling High Blood Pressure	NCQA	x		x			
Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	AMA-PCPI	x			x		
Timely Transmission of Transition Record (Inpatient Discharges to Home/Self-Care or Any Other Site of Care)	AMA-PCPI			x		x	
Patient Satisfaction							
CAHPS® 4.0	NCQA/HEDIS			x	x		Age ranges differ

* American Medical Association's Physician Consortium for Performance Improvement

Endnotes

[1]Congressional Budget Office analysis of the Reconciliation Act of 2010 in a letter to Nancy Pelosi, March 20, 2010; *Estimated Financial Effects of the "Patient Protection and Affordable Care Act of 2009" as Proposed by the Senate Majority Leader on November 18, 2009*. Centers for Medicare & Medicaid Services, Office of the Actuary. December 10, 2009.

[2] S. Zuckerman, A.F. Williams and K.E. Stockley. *Trends in Medicaid Physician Fees, 2003–2008.* Health Affairs. 2009. 28(3):w510-w519.

[3] Adapted from S. Zuckerman, A.F. Williams and K.E. Stockley. *Trends in Medicaid Physician Fees, 2003–2008.* Health Affairs. 2009. 28(3):w510-w519.

[4] *Medicaid Coverage and Spending In Health Reform: National and State-By-State Results For Adults At or Below 133% FPL.* The Urban Institute, May 2010. Available at: http://www.kff.org/healthreform/8076.cfm.

[5] P.J. Cunningham. *State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions.* HSC Research Brief No. 19, Center for Studying Health System Change, March 2011. Available at: http://www.hschange.com/CONTENT/1192/

[6] https://www.cahps.ahrq.gov/content/community/events/webcast_hittest.asp?f=38

[7]Prevention Quality Indicators (PQI), developed to measure hospital admission rates for 16 ambulatory care-sensitive conditions in adult populations, can also be used to evaluate the inappropriate utilization of health care services. http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx.

[8]The NCQA has developed a set of case-adjusted Relative Resource Use measures, which evaluate cost and service delivery frequency and are currently specified for use at the health plan level. States should consider modifying these measures for use at the physician organization level. http://www.ncqa.org/tabid/1231/Default.aspx

[9]Pediatric Quality Indicators (PDI) are a set of measures developed to screen for iatrogenic problems that may be amenable to intervention and prevention by changes at the provider or system levels. http://www.qualityindicators.ahrq.gov/modules/pdi_overview.aspx

[10] U.S. Population Projections. http://www.census.gov/population/www/projections/2009projections.html

[11] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi providing an analysis of the amended reconciliation proposal, March 20, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

[12] http://edocket.access.gpo.gov/2010/pdf/2010-17210.pdf

[13] https://www.cms.gov/pqrs/downloads/2011_PhysQualRptg_MeasureSpecificationsManual_033111.pdf

[14] http://www.federalregister.gov/articles/2012/01/04/2011-33756/medicaid-program-initial-core-set-of-health-care-quality-measures-for-medicaid-eligible-adults

[15] https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/CHIPRACoreSetTechManual.pdf