
SHO #13-007
ICM #4

November 22, 2013

RE: Quality Considerations for Medicaid and CHIP Programs

Dear State Health Official:
Dear State Medicaid Director:

This letter is the fourth in a series of letters on integrated care models (ICMs)¹ that provides states with guidance on designing and implementing care delivery and payment reforms that can achieve our shared goals of improving health, striving for quality care and reducing costs within Medicaid and the Children's Health Insurance Program (CHIP).² In previous and future communications on payment and service delivery reform, we use the term ICMs to describe these initiatives, which may include (but are not limited to) medical/health homes, Accountable Care Organizations (ACOs), ACO-like models, and other health care delivery and financing models, including managed care. Such care models emphasize person-centered, continuous, coordinated, and comprehensive care (see Attachment 3 of SMD #12-002 for further description).

As described in the associated letters in this series, the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) is supportive of new and existing forms of service payments that focus on improving health care quality. These payment strategies may range from risk-based shared savings methodologies to payments that are added to what a provider receives through fee-for-service based on meeting performance expectations -- the common thread is a focus on paying for value and quality.

As Medicaid programs transition away from rewarding volume and toward paying for value with financial incentives to improve outcomes for beneficiaries,³ CMS intends to actively support

¹ On July 10, 2012 CMS released two letters on Integrated Care Models (SMD # 12-001 and #12-002); the first describing our broad vision for payment and delivery system reform and the second describing policy considerations. The July 2012 letters are available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf> and <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>. On August 30, 2013, CMS released SMD number 13-005 on the topic of shared savings, which is available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf>

² In this letter the term Medicaid will be used when referring to Medicaid and CHIP Programs.

³ National Association of Medicaid Directors, "Creating a Climate for Innovation", Nov. 9, 2011. (At <http://medicaiddirectors.org/node/192>).

quality improvement, learning from innovative efforts at the state and local level. While CMS can support system-level thinking around quality improvement, innovation and action will be locally driven.⁴ In order to improve quality through payment, states must have the tools and information needed to undertake quality improvement efforts. Furthermore, it is useful for state Medicaid programs and CMS to have a common understanding of what it means to measure, monitor, and improve the quality of health care in value-based payment models. This letter provides a framework for quality improvement and measurement – developed in consultation with states – consistent with CMS’s and HHS’s approaches in these areas.⁵ Experience has shown that quality improvement and measurement are the foundation for payment models that can improve care and reduce costs, and so CMS will be looking for these types of strategies as states seek approval for new ways to structure payments to providers (e.g. ICMs). Moreover, this framework is relevant beyond just ICMs. As such, CMS encourages states to develop statewide quality strategies that can guide efforts to improve quality across state Medicaid programs, using the components highlighted in this letter.

Section I of this letter describes the features of robust and integrated statewide quality strategies that can be used to drive payment. Section II describes the impact of this framework on CMS policies for payment delivery models and accountability. The appendices contain: 1) a description of existing quality measurement and improvement efforts that impact Medicaid and CHIP; 2) an example of a measurement matrix; and 3) a description of alignment with existing quality initiatives and funding to support data infrastructure.

I. QUALITY IMPROVEMENT STRATEGIES FOR MEDICAID: GOALS, INTERVENTIONS, METRICS, TARGETS, TRANSPARENCY AND FEEDBACK

The following five key components: (1) goals, (2) interventions, (3) metrics, (4) targets, and (5) transparency and feedback, are integral to a state’s quality improvement vision and strategy.⁶ For the purposes of Medicaid, these components, including measurement, should ultimately be laid out in a cohesive plan, and tied together, in the context of what is happening in a state across purchasers related to quality (i.e., which areas need targeted improvement, indicators that will help identify if improvement occurred, etc.).

⁴ VanLare JM, Conway PH. Value-Based Purchasing – National Programs to Move from Volume to Value. NEJM July 26, 2012.

⁵National Quality Strategy 2012 Annual Progress Report to Congress, August 2012. www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf; CMS National Quality Enterprise and Thomson Reuters, [Continuous Quality Improvement: Models and Common Themes \(July, 2009\)](#). Also see “Plan-Do-Study-Act” model; and the Model for Improvement from the Institute for Healthcare Improvement Langley GL, Nolan KM, Nolan TW, Norman CL, and Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Consultation with states has occurred in multiple forums, such as CMCS’s Value-Based Purchasing MAC Collaborative (at www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Value-Based-Purchasing.html).

⁶ Tools such as driver diagrams and run charts can also help visualize some of these components together as pathways. See www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/QI-101-Webinar2-Slides.pdf; <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/QI-101-Webinar3-Slides.pdf>

Stakeholder engagement in designing and implementing each of these components is critical. From consumers, to providers, to patients, multi-stakeholder approaches to quality are not only necessary for viability but have historically been a key to the success of quality improvement initiatives. Stakeholder perspectives and values should be incorporated into this process from the initial conception of a quality improvement model, and should be reflected in the programmatic goals and measurement approaches.

1. Identify shared goals and aims. The foundation of a quality improvement strategy is a set of measurable goals and aims, which are defined as specific opportunities for change for the population. In order to identify the goal or aim, states should start with a data-based baseline analysis (e.g. cost, utilization patterns, health needs of target populations, quality of life issues facing beneficiaries, barriers to care, past performance) of its Medicaid program, and in some cases the health care system overall. This analysis should help states identify which areas need improvement by looking at the root causes of the issues and then target quality improvement resources accordingly. A state can also look to the National Quality Strategy's six domains (e.g., making care safer by reducing harm caused in the delivery of care; promoting effective communication and coordination of care) to help think through how to design its quality improvement strategy goals.

The connection between the goals and the rest of the strategy is a key part of designing an effective strategy. States should consider how the interventions will help achieve these goals as well as how the metrics will measure progress toward these goals. These specific measurable health care quality goals are the drivers for the entire strategy — the interventions, payment model and metrics – should all be rooted in the specific goals identified.

Quality improvement goals can be broad or aimed more narrowly. In some cases, as states and innovators focus on improving in one area with specific quality improvement goals, it may be important to also set broad goals across the program or system in order to ensure that specific efforts are consistent with broader health system goals.

States are also encouraged to examine how their goals can be aligned with existing and newly emerging initiatives, so that such initiatives can be leveraged by the state in its efforts to achieve quality improvement. For instance, it is imperative that states align their quality improvement with efforts to increase meaningful use of health information technology and exchange (HIT/E), since HIT and HIE provide a foundation to support quality improvement measurement across providers. In addition, the Million Hearts Initiative is a broad national strategy aimed at preventing one million heart attacks and strokes over the next five years.⁷ The Partnership for Patients⁸ is a public-private partnership working to improve the quality, safety and affordability of health care for all Americans by focusing on two goals: 1) keeping patients from getting injured or sicker in the health care system and 2) helping patients heal without complications by avoiding readmissions following a stay in a hospital. Programs such as the Partnership for Patients have been developed with stakeholder support and a strong evidence base for improving

⁷ Million Hearts Initiative: www.millionhearts.hhs.gov/aboutmh/overview.html

⁸ Partnership for Patients: www.partnershipforpatients.cms.gov/

care, and hold real promise for improving transitions from acute care hospitals to other care settings.

2. *Select interventions that achieve these goals.* The interventions selected should have a strong evidence base (when possible) for impacting the change that is targeted in the state’s quality improvement strategy, aims and goals. Interventions may consist of payment reforms and delivery reforms, or collaborative quality improvement initiatives. For instance, shared savings arrangements are payment changes that can create incentives to achieve the goal of reduced re-hospitalizations. But even with new incentives, changes in care or the way care is delivered (e.g., community transition programs, health homes, etc.) are still necessary to successfully reduce re-hospitalizations or re-institutionalizations. States may consider conducting several small tests of change and Plan-Do-Study-Act (PDSA) cycles to quickly identify which interventions have the greatest potential to impact change and drive progress towards the goals and aims of the state’s quality strategy.

3. *Measure and monitor progress toward these goals.* Once the goals, aims and interventions for the quality improvement strategy are set, the appropriate metrics that can be directly tied to these goals and interventions must be selected. Using the appropriate metrics will allow a state to understand when a change has resulted in improvement. While designing a measurement approach that will be used to assess progress towards the quality strategy goals, states should consider a blend of process, structure, and outcome-focused quality metrics along with balancing measures that can help to reflect unintended consequences of change to other parts of the system or other systems. For example, a state focused on implementing a medical home model for children can measure asthma admission rates (to reflect outcomes); up-to-date immunizations (to reflect important prevention processes); and/or an experience of care survey (to monitor for unintended consequences). Understanding the quality measurement field is evolving, states should strive to use metrics that closely reflect true outcomes, particularly when there is more risk to the program and beneficiaries (i.e., a shared savings arrangement or capitation).

A broad cross section of metrics beyond the scope of the intervention-specific goals may be necessary to indicate how specific improvements are affecting quality across the program, and they can also indicate if there is any slippage where quality improvement resources are not presently focused. Furthermore, if the focus of intervention-specific goals is on long-term care services and supports, the measurement strategy should reflect the broad range of clinical, psycho-social and community support needs of the population.

Rationale for Measures: When selecting which measures to use, it is important to consider the rationale for selecting each measure and determine how each measure ties to the improvement goal or intervention. This assessment will help the state identify which programmatic goals are and are not reflected with the available measures. In addition, clarifying the connection from goal to measurement is useful in meaningfully conveying to internal/external stakeholders and to CMS what the state intends to achieve and how it will know that progress is occurring.

Alignment with Existing Federal Measurement Programs and with Other State Activity: States are strongly encouraged to select measures recognized by HHS and demonstrated to be evidence-based, to the extent possible. Measures should ideally be endorsed by nationally recognized entities. When metrics are used to determine payment or incentive levels, states must use nationally endorsed metrics, or provide justification for use of non-endorsed metrics for these

purposes of payment. In the absence of nationally endorsed measures, the measures should be validated to establish the same level of scientific rigor that produces consistent and credible results about the quality of care when the measures are implemented. To maximize measurement collection resources and minimize burden of provider reporting, states should begin the selection process with applicable measures already in use by the state as part of other programs or initiatives (e.g., the Medicaid and CHIP child and adult core sets, meaningful use of certified electronic health records (EHRs), managed care programs, section 1115(a) demonstration projects, section 1945 health homes for people with chronic conditions, home and community based services (HCBS) waivers and state plan amendments (SPA), etc.). This process should also include reviewing measures in use by Medicare programs that are relevant to states including, Medicare-Medicaid demonstrations, Physician Quality Reporting System, and Hospital Inpatient Quality Reporting Program.

In order to support alignment with federal programs, the majority of the measures used in CMS's public reporting programs are available online in the CMS measures inventory. The inventory contains detailed measure information for measures in a particular CMS program, see www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html.

An additional resource is the HHS Measures Inventory which contains measures used by CMS and by other HHS Programs. The HHS Measures Inventory is located at www.qualitymeasures.ahrq.gov/hhs/inventory.aspx?pop=yes and contains measurement specifications as they pertain to each individual HHS program, and the measures are searchable by target population or age, condition, care setting and NQF endorsement status. In addition to the CMS measurement work that is underway, there are many HHS cross-agency efforts to develop and align measures and support the National Quality Strategy.⁹

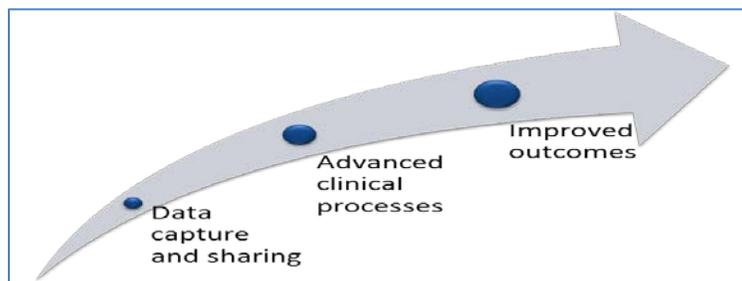
Future Measurement: Quality improvement and measurement is best approached in cycles designed to continuously drive improvement in quality of care and health outcomes. Some goals will likely be precursors to longer range goals, so sequencing of goals and associated measurement is an important aspect of quality improvement and measurement. For instance, in the early phases of implementing a quality improvement strategy, metrics and interventions may be oriented towards building hard and soft infrastructure, and later metrics and interventions will relate more directly to health outcomes. The ability of states to rely on metrics to ensure quality services to beneficiaries may be limited by a paucity of validated outcome measures, particularly for certain domains. States may need to continue to recognize and account for Medicaid services through claims or other intermediate outcome processes that reasonably ensure quality services to beneficiaries, and we encourage states to discuss these approaches with CMS.

⁹ One such effort, modeled after the National Quality Strategy, is the Substance Abuse and Mental Health Services Administration's "National Behavioral Health Quality Framework." The NBHQF has undergone a rigorous review within HHS and via an extensive external set of stakeholders, resulting in a set of recommended core and supplemental measures, many of which are endorsed by the National Quality Forum, and intended to capture key behavioral health activities across HHS. Additional resources can be found on the Agency for Healthcare Research and Quality website: <http://www.ahrq.gov/policymakers/measurement/index.html> and <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/index.html>.

CMS recognizes that in many areas, further measure development is critical and the agency is investing in this field. If there are few available standardized, nationally-validated measures that are appropriate for critical elements of the quality strategy, states should identify which quality improvement areas need to be addressed and then develop a plan for phasing in additional measures to meet these measurement gap areas as validated measures become available.

States can consider using a multi-year glide-path approach to increase the number and complexity of measures used in the program. For example, in the first year of the program, a state could start with mainly process-focused measures, but in the measurement strategy identifying the measures that may be harder to collect but are focused on health outcomes. In these cases, CMS will expect states to transition from process-focused measures toward outcomes measures to the degree feasible.

Graphic 1. Glide path for moving from process focused measurement to outcomes¹⁰



4. Defining the starting point and targets for performance. Using the data-based analysis, previous state performance and national benchmarking data, the state should identify baselines for each of the measures it intends to collect. If states undertaking new initiatives do not have baseline data for their measures, they should create a timeline for identifying and setting baselines, consistent with the glide-path approach mentioned above.

States may choose to provide financial incentives to providers for absolute achievement, targeted improvement on metrics, or both. There are multiple ways to accomplish this. The nature of the split between absolute achievement and targeted improvement will depend on the characteristics of the metric and the basic goals of the effort.¹¹ States may also find CMS’s August 2013

¹⁰ This glide path approach was initially developed for the long-term demonstration of meaningful use of certified EHRs by the HHS Health IT Policy Committee, established under the American Reinvestment and Recovery Act as an official Federal Advisory Committee.

¹¹ For instance, a state may choose to align with CMS’s Hospital Value-Based Purchasing incentive structure, which awards points for both achievement relative to a national benchmark and improvement based on a hospital’s past performance, at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html?redirect=/hospitalqualityinits/>.

Another approach would be to set a target of 90th percentile of national performance for its measures. In brief, providers earn the reward in one of two ways—either the provider meets this performance target, or the provider closes the gap between current performance (baseline) and this 90th percentile target by a pre-specified amount.

guidance on shared savings to be useful to clarify state responsibilities on these financial incentives.¹²

5. Feedback Loops and Transparency

Transparency and feedback help to understand what measures of quality are improving (or not), and create the opportunity for developing and diffusing best practices, avoiding a repeat of problems and driving quality improvement more broadly. A critical element of transparency and feedback is the availability of appropriately structured, reliable and timely data that can support an analysis plan.

There are different kinds of analysis plans. Analysis plans that represent rapid cycle assessment are intended to support mid-course corrections in interventions and to accelerate local learning and improvement. These data may need to be shared, for example, among different provider types or between providers and a health plan who have an active stake in the intervention. Other analysis plans may support the calculation and distribution of incentive payments; these data may not be needed as frequently as is needed for rapid cycle assessment but certainly would need to be complete and reliable. Other analysis plans may be designed to support effective program monitoring or to understand, in robust terms, how an actual set of complex interactions can have differential effects on the quality and cost of care and on health outcomes, perhaps stratified by demographic differences. All of these types of analyses serve different but important roles in driving, understanding and diffusing quality improvement. The latter types are critical to program integrity and policy making.

As part of their state-wide quality strategy, states are also strongly encouraged to consider making quality performance publicly transparent, which is a key ingredient of quality improvement. These data systems are also important to supporting public transparency, for example in producing quality report cards or posting state, plan or provider performance on measures.

CMS recently released guidance on the Transformed Medicaid Statistical Information System (T-MSIS) program, which will be foundational to the effort described in this letter.¹³ Specifically, one of the goals of the T-MSIS effort is to make available robust, timely, and accurate data in order to ensure the highest financial and program performance, support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driven decision making. It is critical that State Health Officials align their T-MSIS efforts, especially related to timing, with the glide path for quality improvement.

¹² [The](http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf) shared savings guidance is available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf>

¹³ CMS State Medicaid Director Letter: Transformed Medicaid Statistical Information System (TMSIS) Data. SMDL# 13-004, August 23, 2013. <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>

A comprehensive, statewide, quality strategy will anticipate these various data needs and include plans for addressing them. Health information exchanges and health information technology infrastructures are helpful in facilitating these data exchanges. Existing policies and a discussion of federal financial participation to support data infrastructure are covered in Appendix 3.

II. IMPACT OF QUALITY STRATEGY ON CMS POLICIES

All states should consider developing a single, statewide comprehensive quality improvement strategy that broadly supports all aspects of a state’s Medicaid program. The approach can help with alignment of a state’s quality improvement activities, identification of resources and can enable CMS to better support a state’s vision for improving health and reducing costs.

Delivery System Payment Models with Accountability for Quality

A robust statewide quality improvement strategy that reflects the components described in this letter, along with validated metrics for pre-defined outcomes, is critical to move to an accountability framework where states rely on measurable improvements as the basis for validating Medicaid quality incentive payments rather than transactional items such as logs and progress reports. CMS expects that states pursuing models that rely on measurable improvements as the basis for validation of payment will be able to articulate a comprehensive quality strategy that describes their overall goals and interventions. This strategy should underlie the measures and reporting processes that will be used to determine the payments, the anticipated improvements or thresholds required to receive payment, any criteria that might limit eligibility to receive payments and the timing and distribution process of the payments.

Measuring quality can be challenging in an environment of evolving measures and systems, but CMS will work closely with states on a model-by-model basis to support flexibility and ensure provider accountability in order to enable states to fully implement these models.¹⁴

An accountability framework based on quality must be supported by a robust data infrastructure to collect, analyze and report metrics. If such an infrastructure does not exist, states should, in partnership with providers, develop sequential goals and metrics over time. Such infrastructure might begin with building the capacity to capture basic electronic health records data and progressively move towards more sophisticated capacities to report and analyze these data elements. We describe the existing policy and federal financial participation to support data infrastructure development, such as TMSIS/MMIS and HIT/E in Appendix 3.

Relationship of Managed Care Requirements and Quality

When developing the overall statewide quality strategy discussed in this letter, states should think broadly across all delivery systems, including managed care. Forty-two states currently use prepaid managed care arrangements to deliver care to Medicaid and CHIP enrollees. Managed care has existing quality requirements and regulations (e.g., 42 CFR Part 438 Subparts D and E), which continue to apply to such programs. The overall statewide quality strategy

¹⁴ Examples of measures used by states in payment reform efforts can be found: www.dhcs.ca.gov/Documents/CA%201115%20Amendment%20Approval%2006.28.2012.pdf (page 314); www.hhsc.state.tx.us/1115-docs/RHP/Category-3-RHP.pdf

described in this letter is one way to fulfill some of these requirements, but these authorities are best understood in the context of the overall statewide Medicaid program quality strategy, as described in this letter.

States operating managed care programs using managed care organizations and pre-paid inpatient health plans are required to conduct External Quality Reviews (EQRs).¹⁵ The EQR process is intended to help states assess and improve the quality of managed care offered by their contracted health plans. There are many ways in which these processes can be improved to better meet the quality improvement needs of states. For example, states could focus current EQR required activities on their performance or outcomes of care, in addition to oversight of the process and structure of managed care delivery systems.

The goals a state seeks to achieve, as laid out in the quality strategy described in this letter, should be reflected in the scope as well as the results of the EQR. Reviewing the EQR performance results allows the state to assess whether new interventions are needed to reach specific health-based goals. In addition, this analysis will assist the state in determining whether its quality strategy is in need of modification. Strengthening the alignment between a state's overall quality strategy and the EQR process will help states achieve improvements in their Medicaid and CHIP programs.

In addition to recent quality improvement work that has been underway related to Medicaid, there are also opportunities to leverage the knowledge base available from Medicare's Quality Improvement Organizations (QIOs) working at the community-level to improve the quality of health care. Since many QIOs are also EQR organizations, there are ample opportunities for synergy of efforts across Medicare and Medicaid.

Ideally, the quality strategy will also be implemented as part of statewide all-payer initiatives to improve quality for all populations, where Medicaid is just one part of that larger effort.

III. CONCLUSION

While states may vary in their approach to designing statewide quality strategies and the ways payment is used to support quality improvement, the components highlighted here should be reflected in all states' strategies. At the same time, we realize that all states are not completely prepared to embark on quality improvement and system reform efforts in the same way—some may use a gradual approach in exploring the enhanced flexibilities while others may delve into large-scale system reform efforts. No matter where a state falls across this spectrum, we encourage states to use this letter as a first step to either begin or expand upon quality conversations with CMS.

¹⁵ 42 CFR Part 438 Subpart E.

We hope this information is helpful. CMS stands ready to partner with states in their ongoing efforts to transition towards accountability based on improvements in health care quality and outcomes. By strengthening and transforming our accountability, we can be better partners in these efforts to improve care, improve the patient experience and reduce costs. Questions about this guidance may be directed to Dr. Stephen Cha, CMCS Chief Medical Officer at stephen.cha@cms.hhs.gov; or discussions can be arranged through the SOTA process.

Sincerely,

/s/

Cindy Mann
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health Operations

Ron Smith
Director of Legislative Affairs
American Public Human Services Association

Matt Salo
President
National Association of Medicaid Directors

Joy Wilson
Director, Health Committee
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Melinda J. Becker
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Appendix 1: Existing Quality Measurement and Improvement Efforts that Impact Medicaid and CHIP

Over the past several years, CMS and HHS have implemented quality-focused activities designed to help states build their quality infrastructures. A comprehensive description of quality programs across HHS is beyond the scope of this guidance. However, included here are several examples of how the department is working to support states.

Initiatives from the Center for Medicare and Medicaid Innovation (CMMI) and the Center for Medicaid and CHIP Services (CMCS) can also provide states with important quality improvement synergies through programs such as Strong Start, the Comprehensive Primary Care Initiative, the State Innovation Models, and the Testing Experience and Functional Assessment Tool in Medicaid Long Term Services/Supports (TEFT) grants. Recently CMS has also released information to support states in addressing quality improvement efforts related to super utilizers¹⁶, mental health parity¹⁷ and prevention¹⁸.

Medicaid.gov – Quality of Care. Includes links to major CMCS quality activities and efforts. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html>

Design and implement quality improvement projects. Quality Improvement 101 webinar series for state Medicaid/CHIP staff launched February 2013). www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/QI-101-Webinar1-Slides.pdf

Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html

Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf

Support for states in becoming value-based purchasers. www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Value-Based-Purchasing.html

Agency for HealthCare Resource and Quality (AHRQ) resource to generate a health care reporting website. The Agency for Healthcare Research and Quality (AHRQ)'s MONAHRQ[®] tool: <http://monahrq.ahrq.gov/>

¹⁶ Super utilizers informational bulletin: <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf>

¹⁷ Mental health parity state health official letter: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf> and state Medicaid Director letter <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf>

¹⁸ Medicaid Prevention Learning Network: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prevention.html>

Meaningful Use of Certified Electronic Health Records (EHRs) and the Medicare and Medicaid EHR Incentive Programs. <http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms>

Transformed Medicaid Statistical Information Systems (T-MSIS). Develop a uniform information and reporting system that will include accurate data for information management and monitoring quality improvement through the transformation of its Medicaid Statistical Information System (MSIS) and the Medicaid and CHIP Program system (MACPro). <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>

Health Homes. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html

Quality for Long-Term Care Populations

- **Integrated approaches to quality improvement strategies, develop national standardized measures, and coordinate quality technical assistance across the across Medicaid authorities supporting long term services and supports.** www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-HCBS.html)
- **Quality in Home and Community-Based Services (HCBS).** www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html and www.medicaid.gov/AffordableCareAct/Provisions/Community-Based-Long-Term-Services-and-Supports.html
- **Money Follows the Person (MFP).** www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html
- **Balancing Incentive Program (BIP).** www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html

Oversight of Quality in Medicaid Managed Care Programs. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Appendix 2: Example of a Measurement Matrix

| Project Goals | Measures Description (title, steward, NQF#) | Alignment to other CMS/State Programs | Baseline | Benchmark | Average Performance Target for Upcoming Year* |
|--|---|--|---|--|--|
| Improving behavioral health and physical health coordination | Follow-up after hospitalization for mental illness (NQF #0576) | Inpatient Psychiatric Facility Quality Reporting, Medicaid Adult Core Set, Children's Core Set, Part C Display Measure | 2011 statewide baseline: 57.6% | 2012 National Medicaid benchmark of 90 th percentile: 68% | 58.6% |
| Improving primary care | Medical assistance with smoking and tobacco use cessation (NQF #0027) | CMS Medicaid Adult Core | 2011 statewide baseline: 50% advised to quit by MD (range 45-58%) | National Medicaid benchmark of 90 th percentile: 81.4% | 53.1% advised to quit |

* Performance targets will be determined for each individual innovator. In this case, each innovator's target is to close 10% of the gap between their own baseline performance and the most recent national Medicaid data for the 90th percentile. An average statewide aggregate performance target for the upcoming year is provided here for reference.

Appendix 3: Alignment with Existing Quality Initiatives, and Funding for Data Infrastructure

Examples of existing efforts where there is the potential for significant quality improvement overlap include (but are not limited to):

- State Medicaid Health information technology (HIT) Plans and statewide HIT strategies
- Health Information Exchange (HIE) Operational Plans
- Medicaid Management Information Systems (MMIS) funding and Medicaid Information Technology Architecture (MITA) efforts
- Grants from the Center for Medicare and Medicaid Innovations, (e.g., State Innovation Models and the Comprehensive Primary Care Initiative)
- Medicaid waiver programs and section 1945 Health Homes initiatives
- State Demonstrations to Integrate Care for Dual Eligible Individuals
- CHIPRA Quality Demonstration Grant Program; and
- Any other funding or strategic plans tied to quality measure alignment and development.

The CMS can support infrastructure and data systems enhancements to support some of these activities through enhanced federal match for design, development and implementation of MMIS. States that modify their MMIS to support the data systems for quality can receive an enhanced 90 percent federal matching payment under section 1903(a)(3) of the Act. This funding includes all staff costs directly attributable to the design, development and implementation of the data system. For continuing operations and maintenance of the MMIS, states can receive a 75 percent federal matching payment. In order to be eligible for the enhanced federal match rate, a state's MMIS must comply with the seven standards and conditions listed in the Federal Register, 76 Fed. Reg. 21950 (April 19, 2011). Additionally, CMS released a set of Frequently Asked Questions on this funding on April 25, 2013.¹⁹

In addition, funding may be available to support State investments in HIE. Under CMS's State Medicaid Director Letter (#11-004) dated May 18, 2011 (and subsequent Frequently Asked Questions²⁰), CMS provided guidance to State Medicaid agencies regarding the implementation of section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub. L. 111-5 and regulations at 42 Code of Federal Regulations (CFR) Part 495, Subpart D. Specifically, this SMD letter provided further detail on Medicaid's contribution (fair share) to HIE infrastructure development to enable Medicaid providers to meaningfully use certified EHRs. This letter also provided more detailed guidance on the State expenditures related to the development of HIE(s) that may be eligible for 90 percent FFP.

¹⁹ <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf>

²⁰ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/FAQ-09-10-2013.pdf>

Depending on the infrastructure development systems and funding authority, states must submit an HIT or a MMIS Advanced Planning Document to CMS for review and prior approval in order to receive this funding. States should consult with CMS prior to submission of federal funding requests to ensure: 1) compliance with the requirements under MMIS and HIT funding authority and 2) that the appropriate funding streams are being leveraged and applied correctly.