

Report to Congress

HHS Secretary's Efforts to Improve the Quality of Health Care for Adults Enrolled in Medicaid



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GLOSSARY

AHRQ	Agency for Healthcare Research and Quality
AOD	Alcohol or Other Drug
ASPE	Assistant Secretary for Planning and Evaluation
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CHF	Congestive Heart Failure
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act
CoIIN	Collaborative Improvement and Innovation Network
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPC	Comprehensive Primary Care
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
HAC	Hospital Acquired Condition
HAI	Healthcare Associated Infection
HCBS	Home and Community-Based Services
HCIA	Health Care Innovation Award
HEDIS	Healthcare Effectiveness Data and Information Set
HEN	Hospital Engagement Network
HHS	U.S. Department of Health and Human Services
HOS	Health Outcomes Survey
HRSA	Health Resources and Services Administration

Innovation Center	Center for Medicare & Medicaid Innovation
LTSS	Long-term Services and Supports
MACBIS	Medicaid and CHIP Business Information Solutions
MCBS	Medicare Current Beneficiary Survey
MHPAEA	Mental Health Parity and Addiction Equity Act
MFP	Money Follows the Person
MLTSS	Managed Long-term Services and Supports
MMCO	Medicare-Medicaid Coordination Office
MSIS	Medicaid Statistical Information System
National Quality Strategy	National Quality Strategy for Quality Improvement in Health Care
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PCPI	Physician Consortium for Performance Improvement
PfP	Partnership for Patients
QHP	Qualified Health Plan
QI	Quality Improvement
QIP	Quality Improvement Project
SAMHSA	Substance Abuse and Mental Health Services Administration
SIM	State Innovation Models
SPA	State Plan Amendment
TA/AS	Technical Assistance and Analytic Support
TEFT	Testing Experience and Functional Assessment Tools

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (Affordable Care Act), enacted in March 2010, created numerous opportunities to improve the quality of health care for adults enrolled in Medicaid. The U.S. Department of Health and Human Services (HHS) has begun implementing a variety of quality improvement activities across a range of health care domains, including physical health, chronic conditions, and acute and long-term care settings.

Through these new quality-focused activities, states and HHS have unique opportunities to better measure, monitor, and improve health care quality for adults. This Report provides a snapshot of the activities underway across state Medicaid agencies and HHS to improve the quality of health care provided to adults enrolled in Medicaid.

Highlights from this Report include the following:

- Preliminary efforts to improve enrollment and stability of health care coverage for adults enrolled in Medicaid. Stable health care coverage plays a critical role in maintaining health and supports HHS's ability to measure and affect the quality of health care provided to individuals.
- Ongoing quality improvement activities and demonstrations designed to address the range of health care conditions and health care settings where adults enrolled in Medicaid receive care, including maternal and infant care, behavioral health, and long-term care services and supports.
- Details concerning HHS's technical assistance and analytic support to states in the first year of states' reporting of the Medicaid Adult Core Set of measures. HHS will continue to support states' efforts to ensure these data are used to drive quality improvements at the state level.

There is much states and HHS can learn by monitoring the successes and challenges of implementing these initiatives. Given the changing health care landscape, HHS does not have recommendations for legislative changes at this time, but will work to continue the implementation of its current statutes and to identify opportunities to strengthen the quality of care provided to adults enrolled in Medicaid.

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (Affordable Care Act), enacted in March 2010, created numerous opportunities to improve the quality of health care for adults enrolled in Medicaid using a variety of vehicles. These include changes to eligibility requirements, demonstrations, and quality measurement sets across a range of health care domains including physical health, chronic conditions, and acute and long-term care settings.

Together, Medicaid and the Children's Health Insurance Program (CHIP) serve 72.8 million Americans.¹ The basis for how the U.S. Department of Health and Human Services (HHS) approaches quality is rooted in the National Quality Strategy for Quality Improvement in Health Care (National Quality Strategy). The National Quality Strategy, required by the Affordable Care Act, was established in 2011 as a national blueprint to improve the health care delivery system and health outcomes by pursuing three goals:² better care, healthy people/healthy communities, and affordable care. These have become the goals of the Centers for Medicare & Medicaid Services (CMS) and are reflected in the activities undertaken by CMS and other HHS agencies to improve care for adults enrolled in Medicaid.

Section 1139B of the Social Security Act, as amended by section 2701 of the Affordable Care Act, includes broad provisions to improve the quality of care provided to adults enrolled in Medicaid. Section 1139B(b)(4) requires that "the Secretary, not later than January 1, 2014, and every 3 years thereafter, shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the [adult Medicaid quality measures]."³ Section 1139A(a)(6) of the Social Security Act, as added by the CHIP Reauthorization Act (CHIPRA) (P.L.111-3) focuses on the Core Set of Health Care Quality Measures for Children in Medicaid and CHIP. Section 1139A(a)(6) calls for a Report to Congress that covers specific topics, which have been adapted to adults for this Report, and include the status of the Secretary's efforts to improve:

- The duration and stability of health insurance coverage for adults under Medicaid (Title XIX)
- The quality of adults' health care under Medicaid, including preventive health services, dental care, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions
- The quality of adults' health care under Medicaid across the quality domains: clinical quality; health care safety; family experience with health care; health care in the most

¹ CMS Statistics Reference Booklet 2013. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf.

² U.S. Department of Health and Human Services. "2013 Annual Progress Report: The National Quality Strategy Improvement in Health Care." Washington, DC: HHS, 2013. Available at: <http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm>.

³ Section 1139B(b)(4) of the Social Security Act.

integrated setting; and elimination of racial, ethnic, and socioeconomic disparities in health and health care

- The status of voluntary reporting by states under Medicaid, using the Medicaid Adult Core Set of Health Care Quality Measures (see Appendix A)
- Recommendations for legislative changes needed to improve the quality of care provided to adults under Medicaid

Section 1139B(d) of the Social Security Act, as added by the Affordable Care Act also requires the Secretary of HHS, beginning September 30, 2014, to release state-reported information on the quality of health care for adults enrolled in Medicaid. The Report to Congress and the 2014 Annual Secretary's Report on the quality of care for adults will provide an overview of the quality of health care improvement initiatives focused on adults enrolled in Medicaid.

States and HHS have, through the Affordable Care Act, new authorities and resources to build on current efforts and establish the foundation for a comprehensive, high quality system of health care services for children and adults. This Report provides a high-level snapshot of several of these efforts across HHS to improve health care quality for adults in Medicaid.

II. HHS EFFORTS TO IMPROVE QUALITY OF CARE FOR ADULTS

A. Efforts to Improve Duration and Stability of Insurance Coverage

Stable health insurance coverage is essential to improving the quality of health care received and experienced by adults in Medicaid. It can reduce financial barriers to health care, particularly for low-income individuals with significant health care needs. It also can link people to primary and specialty health care providers. Ensuring that Americans have access to stable health care coverage and services is at the top of CMS's quality agenda.

The Affordable Care Act contains measures to improve access, affordability, and the overall quality of health care for all Americans. The Medicaid program expansion is one of the ways that the Affordable Care Act expands health care coverage and improves the duration and stability of health care coverage. In implementing the Affordable Care Act, Medicaid eligibility, enrollment, and renewal processes were modernized, building on successful state efforts already underway. Notably, most eligibility verification procedures were moved from paper to electronic data sources. Not all states have expanded their Medicaid programs to date, so the duration and stability of health insurance coverage may vary between expansion and nonexpansion states.

The Affordable Care Act contained multiple provisions designed to streamline the Medicaid eligibility and enrollment process. CMS developed regulations, guidance, and multiple tools to assist states in the implementation of these provisions. Eligibility for most applicants is now determined, in part, using applicants' modified adjusted gross incomes, simplifying the determination and bringing consistency to the way income is counted across the country. The single streamlined application allows applicants the opportunity to apply for coverage in any insurance affordability program (Medicaid, CHIP, and advance premium tax credit/cost-sharing reductions for coverage in a Qualified Health Plan [QHP] through the Marketplace). Applications are accepted online, over the phone, via mail, and in person. The eligibility procedures used by states were also simplified by updating ways to verify eligibility, moving from paper-based to electronic verifications, and increased reliance on self-attestation. Administrative efficiencies have also been gained by changing the process used for renewing a person's eligibility for the program, requiring states to rely on information known to the system before requesting additional information from enrollees.

B. Efforts to Improve Health Care Quality

1. Quality Road Map

In 2013, HHS, CMS, and the states continued to advance efforts to improve the quality of health care for adult Medicaid enrollees. The basis for much of the effort to improve health care quality is the National Quality Strategy. Over the past two years, CMS has used the National Quality Strategy as the road map for improving the delivery of health care services, patient health outcomes, and population health. The National Quality Strategy aims to align new and existing

health care improvement efforts around three goals (better care, healthy people/healthy communities, and affordable care) and to measure progress toward achieving these goals. As Medicaid beneficiaries comprise 21 percent of the nation's population,⁴ it is critical that the quality improvement efforts of Medicaid align with and reflect national quality improvement priorities. CMS has the responsibility of implementing the six goals of the National Quality Strategy:

1. Make care safer by reducing harm caused in the delivery of care.
2. Ensure that each person and family is engaged as partners in their care.
3. Promote effective communication and coordination of care.
4. Promote effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Work with communities to promote wide use of best practices to enable healthy living.
6. Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

In November 2013, CMS released a State Health Official letter setting a framework for quality improvement and measurement that is consistent with the approaches of CMS and HHS in these areas.⁵ In the letter, CMS outlines the features of robust and integrated statewide quality strategies that can be used to drive payment reform and promote shared accountability. This guidance provides a framework for quality improvement and measurement, and encourages states to develop statewide quality strategies to guide efforts to improve quality of care across delivery systems, including managed care.

As detailed below, HHS-led efforts focused on improving preventive health care, chronic and acute care, long-term services and supports, and mental health underscore the need to approach quality health care uniformly and based on a common starting point.

2. Preventive Health Care

Seven of 10 deaths among Americans each year are from chronic diseases, and almost half of all adults have at least one chronic illness. The Affordable Care Act, which calls for a National Prevention Strategy, encourages innovations in health care that prevent illness and disease before they require more costly treatment. HHS, working with the private sector, is focused on preventing chronic disease, encouraging community-level prevention initiatives, reducing the prevalence of obesity, improving maternal and child health, and promoting oral health care.

⁴ Kaiser Family Foundation, State Health Facts. "Medicaid Enrollment as a Percentage of Total Population, 2010." Available at: <http://kff.org/medicaid/state-indicator/medicaid-enrollment-as-a-of-pop/>.

⁵ Centers for Medicare & Medicaid Services. "CMS State Health Official Letter: Quality Considerations for Medicaid and CHIP Programs." SHO #13-007, ICM #4, November 22, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf>.

The National Prevention Strategy was developed by the National Prevention Council, which is comprised of 17 federal agencies in consultation with outside experts and stakeholders.⁶ The strategy provides evidence-based recommendations for improving health and wellness and addressing leading causes of disability and death.⁷ Recommended policy, program, and systems approaches are identified for each strategic direction and priority. In addition, the 2013 Annual Status Report includes a status of National Prevention Council activities and National Prevention Strategy indicators.⁸

CMS is also undertaking large-scale Medicaid-specific prevention initiatives that involve public-private partnerships to pursue the National Prevention Strategy. In 2013, it launched several new activities to support states' efforts to expand access to and improve the quality of preventive health care in Medicaid and CHIP, including:

- The Promoting Prevention in Medicaid and CHIP technical assistance webinar series held in spring 2013 featured presentations on the activities of several state Medicaid programs and their collaborations with federal prevention initiatives, managed care organizations, public health departments, and other stakeholders to improve access to preventive care. The webinar series also provided states with information about successful obesity interventions developed by state Medicaid managed care plans.⁹
- The Medicaid Prevention Learning Network, launched in late fall 2013, aims to help states increase access to and use of preventive services and improve reporting and performance on CMS's prevention-related quality measures. The Learning Network will provide enhanced technical assistance to states and facilitate exchange of information about promising practices of high-impact, effective preventive care delivery.

CMS will be releasing a 2014 Report to Congress which provides additional information on Medicaid-specific prevention and obesity efforts.

⁶ U.S. Department of Health and Human Services. "National Prevention Strategy." Available at: <http://www.surgeongeneral.gov/initiatives/prevention/strategy/index.html>.

⁷ Key indicators will be reported for the overall population and by subgroups as data are available. Indicators and 10-year targets are drawn from existing measurement efforts, especially Healthy People 2020. As data sources and metrics are developed or enhanced, the National Prevention Strategy's key indicators and targets will be updated. Available at: <http://www.healthypeople.gov/2020/about/new2020.aspx>.

⁸ 2013 Annual Status Report: National Prevention, Health Promotion, and Public Health Council. Available at: <http://www.surgeongeneral.gov/initiatives/prevention/2013-npc-status-report.pdf>.

⁹ For more information on the CMS webinar series, "Promoting Prevention in Medicaid and CHIP," see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prevention.html>.

3. Maternal and Infant Health

Nearly two of every three women enrolled in Medicaid are of childbearing age (19 to 44 years) and Medicaid currently finances about 48 percent of all births in the United States.¹⁰ CMS, states, other federal partners, and other stakeholders and experts are engaged in numerous activities to improve the health of mothers and newborns. At the heart of these efforts is an ongoing emphasis on measuring and reporting the quality of maternal and infant health care. CMS's work in this area began several years ago through the Neonatal Outcomes Improvement Project and was further solidified in June 2011 when CMS's Center for Medicaid and CHIP Services (CMCS) and Center for Medicare & Medicaid Innovation (Innovation Center) hosted a Perinatal Symposium that convened thought leaders to discuss opportunities for CMS to improve perinatal care outcomes. The following are examples of the activities underway at HHS to improve maternal and child health among individuals enrolled in Medicaid/CHIP:

- **Strong Start for Mothers and Newborns:** Led by the Innovation Center, the Strong Start for Mothers and Newborns Initiative includes two primary strategies: (1) testing ways to encourage best practices for reducing the number of early elective deliveries that lack medical indication across all payer types; and (2) a grant program to test and evaluate four models of enhanced prenatal care for reducing preterm births and decreasing the cost of medical care during pregnancy, delivery, and the first year of life. In February 2013, 27 recipients received awards to support the testing of enhanced prenatal care in three settings: group or centering visits, at birth centers, and at maternity care homes.¹¹
- **Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP:** CMS's contractor, Provider Resources Incorporated, convened this expert panel quarterly from June 2012 to July 2013 to explore policy and reimbursement opportunities for Medicaid programs to provide better care, improve birth outcomes, and reduce the costs for mothers and infants. In August 2013, the strategies proposed by the expert panel were presented to CMS leadership for consideration as CMS develops implementation plans to improve birth outcomes based on potential impact, available resources, and partnership opportunities. These strategies included enhanced maternal care management, reproductive health, perinatal payment, data measurement, and reporting. Over the next several months, CMS will develop implementation plans for the policy opportunities identified.¹²

¹⁰ Markus, A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." *Women's Health Issues*, vol. 23, no. 5, pp. e273–e280.

¹¹ The fourth model, home visiting implemented by the Health Resources and Services Administration (HRSA), will also be evaluated along with the other three enhanced models of care.

¹² For more information on the CMCS Maternal and Infant Health Initiative, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Maternal-and-Infant-Health-Initiative.pdf>.

- **Collaborative Improvement and Innovation Network (CoIIN):** The CoIIN is a public–private partnership composed of the Health Resources and Services Administration (HRSA), CMS, the Centers for Disease Control and Prevention (CDC), state leaders, and others focused on identifying and sharing innovations and evidence-based practices to improve birth outcomes. CoIIN teams are currently working in 13 Southern states (Regions IV and VI) to reduce infant mortality by providing interconception care management services to women who had adverse pregnancy outcomes. The teams also focus on improving data linkages across Medicaid agencies and departments of public health to facilitate the sharing of vital statistics information. The CoIIN to reduce infant mortality has launched in an additional 6 states of the Midwest (Region V), and is planned to expand to all remaining states by the end of 2014.

CMS has undertaken other efforts to improve infant health outcomes. In June 2011, CMS provided guidance to states on coverage of comprehensive tobacco cessation services for pregnant women through Medicaid.¹³ In 2012, CMS produced an issue brief on Medicaid Coverage of Lactation Services and collaborated with the Association of Women’s Health, Obstetric and Neonatal Nurses to disseminate the brief.¹⁴ Currently, CMS is working with the Medicaid Medical Directors Learning Network to support quality improvement efforts focused on reducing early elective deliveries and enhancing state data capacity using matched vital records and Medicaid eligibility/claims data. Additionally, CMS launched the following other maternal- and infant-related quality improvement and demonstration projects:

- Under the Adult Medicaid Quality Grants, 10 states are implementing quality improvement projects related to maternal and infant health; of these, 5 states are implementing projects to reduce early elective deliveries and all states are working to improve other measures of maternal health.
- Under the CHIPRA Quality Demonstration Grants, two states (Florida and Illinois) are working to reduce early elective deliveries to improve maternal and infant outcomes.¹⁵
- In August 2013, CMS launched a Quality Improvement (QI) Learning Series (QI 201), building on the successful QI 101 webinar series attended by nearly 500 people. The QI 201 Series involves 10 teams focused on developing and implementing specific maternal and infant health projects tailored to their own state needs.

¹³ The Affordable Care Act requires Medicaid to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women. See <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smdl11-007.pdf>.

¹⁴ Centers for Medicare & Medicaid Services. “Lactation Services Issue Brief.” 2012. Available at: http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf.

¹⁵ 2014 Report to Congress: HHS Secretary’s Efforts to Improve Children’s Health Care Quality in Medicaid and CHIP.

4. Oral Health

HHS currently supports a broad spectrum of oral health activities aimed at improving the nation's oral health through financing, research, workforce development, public health action, quality initiatives, and technology.¹⁶ The HHS Oral Health Initiative's key message is that "Oral Health is Integral to Overall Health." This initiative uses a systems-based approach to create and finance programs to emphasize oral health promotion and disease prevention, increase access to care, enhance the oral health workforce, and eliminate oral health disparities. HHS is also working with national and state partners to build on the recommendations set forth in two recent Institute of Medicine reports on oral health as well as the Surgeon General's Report and the National Call to Action to Promote Oral Health.

CMS is leading two efforts specific to improving oral health care for adults enrolled in Medicaid:

- As part of its Oral Health Initiative,¹⁷ CMS launched an educational campaign in September 2013 targeting oral health education for pregnant women.¹⁸
- In collaboration with the Administration on Community Living and the HHS Office on Women's Health, CMS facilitated multiple discussions with senior leadership from its Center for Clinical Standards and Quality to explore opportunities to leverage pending updates to nursing home certification requirements. Additionally, CMS released related guidance to strengthen resident care standards in long-term care facilities and to improve dental and oral health screening, treatment, and maintenance practices in these settings.

5. Acute and Chronic Health Care

HHS is working to improve the quality of health care for adults in Medicaid with acute and chronic care conditions through a variety of activities, including guidance to states on reducing readmissions and demonstrations designed to test improvements in care for adults who are dually enrolled in Medicaid and Medicare. HHS is also involved in the following initiatives:

- In July 2013, CMS released an informational bulletin providing guidance to Medicaid programs interested in implementing super-utilizer programs. Super-utilizers are individuals with complex, unaddressed health issues and a history of frequent encounters with health care providers, such as emergency departments or hospital inpatient admissions. CMS's informational bulletin provided details of care delivery and payment models to help states and Medicaid providers better meet the complex needs of the highest utilizers of acute care in Medicaid populations. It also provided

¹⁶ For more information on the HHS Oral Health Initiative 2010, see <http://www.hrsa.gov/publichealth/clinical/oralhealth/hhsinitiative.pdf>.

¹⁷ For more information on the CMS Oral Health Initiative, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-Dental-Care.html>.

¹⁸ Oral Health Education Campaign. Available at: <http://www.insurekidsnow.gov/professionals/dental/index.html>.

details of existing Medicaid funding mechanisms and policies that can support super-utilizer programs.¹⁹

- Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit to enable states to establish health homes to coordinate care for child and adult Medicaid enrollees with chronic conditions.²⁰ The health home service delivery model integrates and coordinates all primary, acute, and behavioral health care, and long-term services and supports (LTSS) to create a person-centered system of care that achieves improved outcomes for beneficiaries and improved value for state Medicaid programs. CMS is collaborating with federal partners, including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the HHS Assistant Secretary for Planning and Evaluation (ASPE), to ensure an evidence-based approach and consistency in implementing this statutory provision.²¹ As of July 2013, 12 states have at least one approved Health Home State Plan Amendment (SPA) and 19 others have submitted an SPA or a planning request to CMS.²²

CMS will monitor the impact of the health home provision. A 2014 Report to Congress provides more detailed information about this program. Section 1945(f) of the Social Security Act requires states that implement health homes to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum. States are also expected to track emergency room visits and skilled nursing facility admissions for the evaluation.²³

6. Behavioral Health

HHS supports several initiatives to promote behavioral health for adults in Medicaid, including prevention of substance use, violence, and suicide. Over the past several years, CMS has released multiple Informational Bulletins and State Health Official letters designed to inform and support state Medicaid agencies to improve mental health and prevent substance use for adults enrolled in Medicaid:

¹⁹ CMS and the Center for Medicaid and CHIP Services. “CMCS Informational Bulletin: Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality.” July 24, 2013. Available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf>.

²⁰ For more information on Health Homes, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.

²¹ CMS State Medicaid Director Letter, Health Homes for Enrollees with Chronic Conditions, SMDL #10-024, November 16, 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

²² CMS State Health Home CMS Proposal Status (effective July 2013). Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v32.pdf.

²³ CMS State Medicaid Director Letter, Health Homes for Enrollees with Chronic Conditions, SMDL #10-024, November 16, 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

- CMCS Informational Bulletin: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations²⁴
- State Health Official Letter: Application of the Mental Health Parity and Addiction Equity Act (MHPAEA)^{25,26}
- CMCS Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions²⁷

CMS continues to learn how to improve the quality of care for Medicaid-enrolled adults with behavioral health conditions through demonstration programs:

- As part of the CMS Adult Medicaid Quality Grants, 17 states have chosen to develop and implement Quality Improvement Projects (QIPs) focused on improving the quality of behavioral health care services provided through Medicaid. For example, Massachusetts, Pennsylvania, and Vermont are focused on increasing the rate of Medicaid beneficiaries who initiate and engage in alcohol and other drug dependence treatment. Other states have chosen to implement behavioral health projects focused on improving follow-up after mental health hospitalization, improving medication adherence (antidepressant medication management and/or antipsychotics), integrating physical health and behavioral health care, and increasing depression screening and treatment.
- The Medicaid Emergency Psychiatric Demonstration, created under Section 2707 of the Affordable Care Act, tests whether Medicaid can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable.²⁸ CMS worked collaboratively with private nonprofit organizations and across HHS to develop this demonstration. Partners included the National Association of Psychiatric Health Systems and, within HHS, ASPE and SAMHSA. Eleven states and the District of Columbia are participating.

²⁴ CMCS Informational Bulletin: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations, August 24, 2012. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-08-24-12.pdf>.

²⁵ CMS State Health Official Letter, Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans, SHO #13-001, January 16, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

²⁶ CMS has also developed a tool for states to use to assess their Medicaid Alternative Benefit Packages to ensure they adhere to MHPAEA (see <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>).

²⁷ CMCS Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions, March 27, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf>.

²⁸ For more information on the Medicaid Emergency Psychiatric Demonstration, see <http://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/>.

7. Care for High-Need, High-Cost Populations

A significant segment of the Medicaid population has high needs and high costs.²⁹ Working with its state partners, CMS has developed several initiatives to improve the availability, affordability, and quality of services for high-need, high-cost Medicaid populations, including efforts to integrate care for people who are dually eligible for Medicare and Medicaid as well as programs that tailor LTSS services to the individualized needs of the population:

- The Medicare-Medicaid Coordination Office (MMCO) in CMS improves care for people who are dually eligible for Medicare and Medicaid. MMCO is sponsoring the Financial Alignment Initiative,³⁰ a demonstration for states and the federal government to improve coordination and alignment of care for Medicare/Medicaid enrollees. These demonstrations provide states with new vehicles to test innovative financing and delivery models that better integrate Medicare and Medicaid services, improve care delivery and beneficiary experience, and reduce unnecessary spending for this population.
- CMS's National Partnership to Improve Dementia Care in Nursing Homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings.

8. Community-Based Long Term Services and Supports

An estimated 4.2 million Medicaid beneficiaries used LTSS in federal fiscal year (FFY) 2010, representing about 6.4 percent of the total Medicaid population.³¹ HHS works with states to ensure and improve quality across the Medicaid authorities that support community-based LTSS services, including the Medicaid 1915(c) Home and Community-Based Services (HCBS) waiver program—the largest single payer of long-term care services in the country. Over the past

²⁹ Three pathways to Medicaid eligibility are available to the high-cost, high-need Medicaid population: (1) people who are eligible for Medicaid because they have a disabling condition that precludes them from working, (2) people who have high levels of health care utilization and spending that qualify them for Medicaid when they spend down their income, and (3) people covered by Medicare who also qualify for Medicaid because they have low incomes and need LTSS.

³⁰ For more information on the Financial Alignment Initiative, see <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>.

³¹ Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. Washington, DC: MACPAC, June 2013, p. 102. Available at: https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2013-06-15_MACPAC_Report.pdf?attachauth=ANoY7coHHTq8MxqIcJzg-OrpAuCLudy2gsaE_JR50uYSIjLRiS_5dRaZgqAL2VuJ3pHivhKpWn0DAuk_IgHG9CBEc3-xpHEhxmj9hHQ-NauYrDXvGjPUOFzGku8dk_ch70NI9N_iCufMOvRaa70OSVBis4ebFtT6nWuRZOxc53WDhrLqU1Wnnc-SVpnl4eKYKWWg8hUX5oFxyUYqJGJMklxjCnCcL0Xh_cWtECaz0ZEvrIRbSATsu2M%3D&attredirects=0.

several years, CMS has partnered with states to improve the quality of managed long-term services and supports (MLTSS) by issuing principles³² for state MLTSS programs and providing other state resources such as a May 2013 Informational Bulletin outlining the essential elements of strong MLTSS programs.³³ Additionally, ASPE conducted a study of five participant-directed MLTSS programs in the following five states: Arizona, Massachusetts, New Mexico, Tennessee, and Texas.³⁴

A variety of grant programs and demonstrations are also underway to improve the quality of care for adults in Medicaid LTSS programs:

- The Testing Experience and Functional Assessment Tools (TEFT)³⁵ grant program focuses on leveraging innovation in health information technology by testing quality measurement tools and demonstrating e-health in Medicaid LTSS for the first time at a national scale. CMS will select up to 10 eligible state applicants to (1) test and evaluate new measures of functional capacity and individual experience for populations receiving community-based LTSS, (2) identify and harmonize the use of health information technology, and (3) identify and harmonize electronic LTSS standards.³⁶
- The Money Follows the Person (MFP) Rebalancing Demonstration was designed to provide flexibility to states to remove barriers and improve an individual's access to community supports and independent living arrangements, and to enable states to provide care under a waiver or through state plan options. With grants of \$1.44 billion over five years, it is the largest demonstration program of its kind in the history of Medicaid. States use the grant funds to develop systems and services to assist in moving long-term residents of nursing facilities, intermediate care facilities for individuals with mental retardation, and psychiatric hospitals back home or to community-based settings. States also are increasing efforts to shift Medicaid long-term care spending permanently toward community-based care and services.³⁷

The national MFP demonstration marked its fifth full year of implementation in 2012. Most programs are achieving required transition and expenditure goals and data

³² For more information on CMCS's managed long-term care resources, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html>.

³³ CMCS Informational Bulletin: Long Term Services and Supports Delivered Through Medicaid Managed Care Programs. May 21, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-05-21-2013.pdf>.

³⁴ Participant-Directed Services in Managed Long-term Services and Support Programs: A Five State Comparison. Washington, DC: Office of Disability, Aging and Long-Term Care Policy, August 2013. Available at: <http://aspe.hhs.gov/daltcp/reports/2013/5LTSS.pdf>.

³⁵ For more information on the TEFT funding opportunity, see <http://www.medicaid.gov/AffordableCareAct/Downloads/TEFT-FOA-9-10.pdf>.

³⁶ The TEFT initiative includes contracts for technical assistance and evaluation and interagency agreements with the Department of Defense and the Office of the National Coordinator.

³⁷ For more information on Money Follows the Person, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html>.

indicate that states are continuing to shift LTSS expenditures toward community-based services. In 2012, states were still in the initial phase of expending their MFP rebalancing funds that they accumulated as they provide services to MFP participants.

- CMS has also implemented two other programs, Community First Choice³⁸ and the Balancing Incentive Program,³⁹ to support states in moving beneficiaries out of institutions and into the community. Community First Choice creates a new state plan option to provide home and community-based attendant services and supports. This option will enable states to receive a 6 percent increase in federal matching funds for providing community-based attendant services and supports to Medicaid beneficiaries. States may also cover costs related to moving individuals to the community. The Balancing Incentive Program offers a Federal Medical Assistance Percentage (FMAP) increase of two or five percentage points to states whose current expenditures on community-based LTSS comprise less than 50 percent of their overall spending on LTSS, and that undertake structural reforms to increase nursing home diversions and access to noninstitutionally-based services.

C. Cross-Cutting Efforts Across Health Care Quality Domains

HHS is undertaking multiple efforts across various domains to improve the quality of health care delivered to adults in Medicaid, including delivery system innovations, patient safety, family experiences with health care, and health care disparities.⁴⁰

1. Delivery System Innovations

CMS's Innovation Center supports initiatives that test new models for delivering and paying for health care, with the ultimate goal of creating systems that offer high quality care at lower costs to Medicare, Medicaid, and CHIP beneficiaries.⁴¹ Several initiatives have the potential to provide higher quality care to adult beneficiaries:

- The Comprehensive Primary Care (CPC) initiative provides funding to states to offer additional reimbursements to Medicaid providers that offer comprehensive care management, with the goal of increasing the quality of primary care available to Medicaid beneficiaries.⁴²

³⁸ For more information on Community First Choice, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Community-First-Choice-1915-k.html>.

³⁹ For more information on Balancing Incentive Program, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html>.

⁴⁰ An additional domain, clinical quality, is discussed throughout the Report.

⁴¹ For more information on the CMS Health Care Innovation Awards, see <http://www.medicaid.gov/State-Innovations.html>.

⁴² Center for Medicare & Medicaid Innovation. "Comprehensive Primary Care Initiative Fact Sheet." August 22, 2012. Available at: <http://innovation.cms.gov/Files/fact-sheet/CPCI-Fact-Sheet.pdf>.

- The State Innovation Models (SIM) initiative funds state efforts to design and test multi-payer payment and delivery models that will improve the quality of health care, particularly for Medicare, Medicaid, and CHIP beneficiaries.⁴³
- Through the Health Care Innovation Awards (HCIAs),⁴⁴ CMS is funding up to \$1 billion for awards and evaluation of projects across the country that test new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and CHIP enrollees. CMS is currently evaluating proposals from the second round of funding.

2. Patient Safety

CMS established the Partnership for Patients (PfP) in 2011. The PfP combines the efforts of multiple partners and federal and non-federal programs, in an aligned effort to improve patient safety by reducing preventable Hospital-Acquired Conditions (HACs) by 40 percent and 30-day readmissions by 20 percent. The PfP partnership is comprised of more than 3,700 participating hospitals distributed throughout all 50 states, all of which have committed to improve care by teaming in their quality improvement work with one of 27 Hospital Engagement Networks (HENs). To facilitate this effort, the HENs have established infrastructure and organized technical assistance programs to support these hospitals in improvement and measurement activities, engaging with patient and families, learning, reporting, and generating results. These hospitals are joined by a complementary Innovation Center program investment in more than 100 community coalitions supported through the Community-based Care Transitions Program to assist high-risk Medicare patients with care transition services to reduce their risk of hospital readmissions. Private partners, together with other federal agencies, have aligned their resources and programs to support rapid action and progress in these hospitals and communities. Priority areas of focus in the PfP initiative include reducing inpatient adverse events, such as adverse drug events, central line-associated blood stream infections, catheter-associated urinary tract infections, and obstetric events such as early elective deliveries, as well as reducing 30-day readmissions through better care transitions.⁴⁵

In June 2011, CMS published a final rule implementing Section 2702 of the Affordable Care Act, which prohibits federal Medicaid payments to states for care provided to treat health care-acquired conditions.⁴⁶ The final rule required states to implement nonpayment policies for a range of provider-preventable conditions, which include health care-acquired conditions (applicable to any inpatient hospital settings in Medicaid), as well as other provider-preventable conditions (applicable to any health care setting). This policy is intended to provide an incentive for providers to apply best practices in order to prevent secondary conditions and prevent adverse outcomes.

⁴³ For more information on the CMS State Innovation Models Initiative, see <http://innovation.cms.gov/initiatives/state-innovations/index.html>.

⁴⁴ For more information on the round two of the Health Care Innovation Awards, see <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html>.

⁴⁵ For more information on Partnership for Patients, see <http://partnershipforpatients.cms.gov/about-the-partnership/what-is-the-partnership-about/lpwhat-the-partnership-is-about.html>.

⁴⁶ “Medicaid Program: Payment Adjustment for Provider-Preventable Conditions,” 76 Fed. Reg. 32816, June 6, 2011.

The Agency for Healthcare Research and Quality (AHRQ) is also supporting activities that target the prevention and mitigation of various threats to patient safety with a common objective of improving health care quality and reducing patient harm. For example, AHRQ has concentrated a major portion of its attention and resources on the problem of healthcare-associated infections (HAIs). HAIs are a significant cause of illness, death, and excess cost in all health care settings, and AHRQ conducts a robust program aimed at preventing and reducing HAIs. The program combines supporting research on improved methods for combating HAIs with promoting the wide-scale implementation of proven methods for preventing these deadly infections. AHRQ also strives to collaborate and coordinate effectively with Federal partners and other entities in order to align and synchronize related activities, avoid unnecessary duplication and overlap, and optimize their combined impact. Additional information about AHRQ's projects and products that aim to improve quality and safety by preventing HAIs and other threats to patient safety can be found at <http://www.ahrq.gov>.

3. Family Experiences with Health Care

An important dimension of quality is the patient's or family's experience with care. Experience can be measured globally (such as overall experience of care with the health plan or ability to get needed care) or in relation to a specific event or encounter (such as a medical visit, hospitalization, or nursing home stay). AHRQ supports and promotes the assessment of consumers' experiences with health care through its Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys.⁴⁷ Examples of other surveys that include adult Medicaid enrollees are the Hospital CAHPS and the CAHPS Home Health Care Surveys.

CMS has two efforts underway to collect Medicaid-specific information about adults' experiences with health care:

- In 2010, CMS funded the development of a patient experience survey that addresses the specific needs of the HCBS population. For example, the survey uses alternative wording for people who have difficulty using response options about the frequency of a particular event ("always/sometimes/never"), which was found to be an issue for a significant portion of the HCBS population. It also includes a set of questions on community inclusion and empowerment. The survey also includes new questions on the quality of HCBS that previously were not collected in a standardized way across states. The survey is currently being field-tested.
- CMS plans to conduct a nationwide CAHPS survey of adult Medicaid beneficiaries in 2014.⁴⁸ The goal of this survey is to obtain national and state-by-state estimates of Medicaid adult beneficiaries' access and experience with care across financing and delivery models (for example, managed care and fee-for-service) and population groups (such as disabled or dually eligible individuals). The survey results will serve as baseline information on the experiences of low-income adults during the early stages of implementation of the Affordable Care Act.

⁴⁷ For more information on CAHPS, see <http://cahps.ahrq.gov/about.htm>.

⁴⁸ The CAHPS Medicaid survey 5.0H will be used to obtain information on the experiences of care of adults covered by Medicaid.

4. Health Care Disparities

Health disparities have been defined as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.”⁴⁹ Disparities are documented in many conditions and in access to health care for adults and children. A number of HHS initiatives seek to eliminate racial, ethnic, and socioeconomic disparities in health and health care, and to ensure more accurate data collection across population subgroups.

The Affordable Care Act includes several provisions to address health and health care disparities, including provisions focused on workforce development, quality of care, prevention and health promotion, prohibiting discrimination in health care programs, and data collection and analysis. One of the key provisions relates to improving data collection and analysis, which will enable a better understanding of the needs, gaps, and opportunities to eliminate health disparities. Section 4302(a) of the Affordable Care Act added new Title XXXI to the Public Health Service Act (42 U.S.C. 300k et seq.). Section 3101(a)(1)(A) of the Public Health Service Act now requires HHS to develop data collection standards for five demographic categories: race, ethnicity, sex, primary language, and disability status. It requires that any federally conducted or supported health care or public health program, activity, or survey collect and report data on these categories to the extent practicable. The final data standards apply to the collection of data in HHS-sponsored population surveys in which person-level data are collected via either self-report or from a respondent who serves as a knowledgeable household representative.⁵⁰

Section 4302(b) of the Affordable Care Act, adding section 1946 to the Social Security Act, also requires that the Secretary evaluate approaches for collecting and evaluating data on health care disparities in Medicaid/CHIP, and this evaluation has already led to changes in the collection and analysis of Medicaid and CHIP data, including the following:

- Integrating many of the Section 4302 data elements into the single, streamlined application that is used to determine eligibility in the new insurance marketplaces.
- Updating the data dictionary for the Medicaid Statistical Information System (MSIS), CMS’s primary, claims-based data system, to include the Section 4302 data elements.
- Testing states’ ability to stratify by gender, race/ethnicity, language, disability status, and geography a subset of the Medicaid Adult Core Set measures through the Adult Medicaid Quality Grant program.
- Updating the Medicare Current Beneficiary Survey (MCBS), a nationally-representative survey that serves as a comprehensive source of information on the health status, health care use, and expenditures of Medicare beneficiaries, to collect the race, ethnicity, sex, primary language, and disability status variables in accordance with Section 4302. The MCBS has important implications for Medicaid policy, as 14

⁴⁹ The Healthy People 2020 definition of health disparities is available at: <http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx>.

⁵⁰ For more information on Office of Management and Budget Standards for Data on Race and Ethnicity, see <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=172>.

percent of Medicaid enrollees (9.6 million) are low-income elderly adults or people with disabilities under age 65 who are enrolled in both the Medicare and Medicaid programs.⁵¹ Over the next few years, all CMS Medicare surveys will be adding these new variables, including CAHPS surveys and the Medicare Health Outcomes Survey (HOS).

A forthcoming Report to Congress will include recommendations for improving the identification of health care disparities for Medicaid and CHIP enrollees based on analyses of information collected under this provision to date.

Further, AHRQ, in partnership with CMS, recently produced the report, Health Care Coverage Analyses of the National Healthcare Quality and Disparities Reports: 2000–2008 Trends,⁵² an update to the 2008 report, Health Care Coverage Analyses of the 2006 National Healthcare Quality and Disparities Reports. This report observes how quality and access have changed over time for individuals with private insurance, Medicaid, and no insurance, and examines racial and ethnicity disparities within insurance group, using data available from the National Healthcare Quality and Disparities Reports.

Further complementing these activities is the HHS Disparities Action Plan, which builds on the Affordable Care Act and outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minority groups.⁵³ CMS is the lead agency for a number of actions in the HHS Disparities Action Plan, and several of the overarching Secretarial priorities are specific to CMS, including an initiative focused on improving access to dental care for children in Medicaid and CHIP. CMS's Office of Minority Health is planning a QIP to reduce health care disparities in diabetes care for Medicare and Medicaid dually-eligible beneficiaries.

⁵¹ Kaiser Commission on Medicaid and the Uninsured. "Medicaid's Role for Dual Eligible Beneficiaries." Menlo Park, CA: The Henry J. Kaiser Family Foundation, August 2013.

⁵² "Health Care Coverage Analyses of the National Healthcare Quality and Disparities Reports: 2000–2008 Trends." Washington, DC: HHS, 2014. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Health-Coverage-Analyses-of-NHQR-2000-2008-Trends.pdf>.

⁵³ "HHS Action Plan to Reduce Racial and Ethnic Health Disparities." Washington, DC: HHS, 2011. Available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

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III. STATUS OF VOLUNTARY REPORTING BY STATES

Section 1139B of the Social Security Act required the Secretary of HHS to establish a comprehensive adult health care quality measurement program to standardize the measurement of health care quality across state Medicaid programs and facilitate the use of the measures for quality improvement. This provision calls for HHS to identify and publish a core set of health care quality measures for adults enrolled in Medicaid (Medicaid Adult Core Set). Similar to the Core Set of Children's Health Care Quality Measures, which just completed its third year of reporting, state reporting of the Medicaid Adult Core Set is voluntary. The provision of technical assistance and analytic support is intended to build states' capacity for collecting, calculating, and reporting the measures and to encourage states to use the measures to drive quality improvement.

In addition to the Medicaid Adult Core Set, HHS has numerous activities underway to ensure alignment in the development of quality measures. Two examples are the HHS Measurement Policy Council and the HHS Measurement Coordination Group. The Measurement Policy Council is a cross-departmental group that reviews and makes recommendations and/or approvals concerning HHS measure alignment, new measure development and implementation, and measure policy. Working closely with the Measurement Policy Council is the HHS Measurement Coordination Group, which provides operational support to the Measurement Policy Council and is charged with coordinating quality measurement work across HHS divisions. The goal of these two HHS-level efforts is to ensure departments are aware of measurement development activities and to identify opportunities to reduce duplication and increase alignment.

An additional opportunity to align measurement efforts focused on adults in Medicaid are the measures to be used by the QHPs. Although quality reporting and quality-related activities will not begin until 2016, QHPs will implement and report on quality improvement strategies to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce disparities in health and health care. CMS is currently developing the core measure set for the QHPs, with a goal of choosing measures consistent with existing core measure sets to create a seamless, coordinated insurance program.

A. The Medicaid Adult Core Set

In January 2012, CMS published the Medicaid Adult Core Set (Appendix A).⁵⁴ The core set of 26 measures was identified in partnership with a subcommittee to AHRQ's National Advisory Council. This multi-stakeholder group composed of state Medicaid representatives, health care quality experts, and representatives of health professional organizations reviewed and evaluated

⁵⁴ "Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults." Federal Register Notice 77 FR 286. Washington, DC: HHS, January 4, 2012. Available at: <https://www.federalregister.gov/articles/2012/01/04/2011-33756/medicaid-program-initial-core-set-of-health-care-quality-measures-for-medicaid-eligible-adults>.

approximately 1,000 measures from nationally recognized sources, including measures endorsed by the National Quality Forum (NQF). The subcommittee broke into four work groups to focus on four dimensions of health care for adults enrolled in Medicaid: adult health, maternal/reproductive health, complex health care needs, and mental health and substance use.

Following review and public comment, the subcommittee selected 26 measures across six domains: prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, care coordination/care transitions, and availability. The Medicaid Adult Core Set measures align with other federal quality improvement initiatives, including the Medicare/Medicaid Electronic Health Record Incentive Payment Program, National Quality Strategy, Health Home Core Set, Strong Start Initiative, Medicare Shared Savings Program, Physician Quality Reporting System, and the Partnership for Patients.

States have been asked to voluntarily report the measures for the first time in FFY 2014. The legislation requires that improvements to the initial core set of adult health care quality measures be issued annually beginning in January 2014. CMS sees this as a unique opportunity to meet its goal of continuing to fill measurement gap areas in the core set and apply states' feedback about implementing the measures. Over the next year, CMS will focus on measurement development efforts around managed LTSS and the Health Home Program, as well as filling other key gap areas, such as measures for care coordination and patient-reported outcomes.

B. Medicaid Adult Quality Grants

To assist states in collecting and reporting the Medicaid Adult Core Set, CMS launched the Medicaid Adult Quality Grants program in December 2012. Funded by the Affordable Care Act, CMS selected 26 states to participate in the two-year grant program.⁵⁵ Each state receives up to \$1 million per year for the two-year project period. The program has three main goals:

- Test and evaluate methods for collecting and reporting the Medicaid Adult Core Set in varying care delivery settings and payment arrangements, ideally demonstrating alignment with existing methods and infrastructures for collection and reporting
- Develop staff capacity to report, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid
- Conduct at least two Medicaid QIPs related to the core set measures; states are encouraged to consider alignment for QIPs with CMS or other federal quality improvement activities (such as Strong Start, Million Hearts, and Partnership for Patients)

⁵⁵ The states are Alabama, Arkansas, California, Colorado, Connecticut, Georgia, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia.

C. Standardized Reporting Format for the Medicaid Adult Core Measures

As set forth in the Affordable Care Act, Section 1139B of the Social Security Act requires HHS to develop a standardized reporting format for the Medicaid Adult Core Set. CMS has continued to make progress in moving toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for the CMS's quality reporting and performance measurement capacities for Medicaid and CHIP. In the interim, CMS will use CARTS as the vehicle for collecting data on the Medicaid Adult Core Set. CARTS is the web-based data submission tool that states use to report the Child, Medicaid Adult, and Health Home Core Set measures to CMS. It is CMS's expectation that these longer-term efforts will help ensure that information is more accurate, complete, and uniform, and will reduce burden on its state partners. CMS believes, furthermore, that standardized reporting has the potential to strengthen quality reporting for adults, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for adults in Medicaid.

To further support states in collecting and reporting the Medicaid Adult Core Set measures, CMS released technical specifications for the Medicaid Adult Core Set in February 2013.⁵⁶ CMS will release annual updates to the technical specifications, in accordance with measure steward updates and other clarifications to assist states with reporting the measures.

D. Technical Assistance and Analytic Support to States

To encourage and support states to report the Medicaid Adult Core Set measures, CMS implemented a Technical Assistance and Analytic Support (TA/AS) Program.⁵⁷ The overarching goals of the TA/AS Program are to increase the number of states consistently collecting and uniformly reporting the Medicaid Adult Core Set measures and to help states use these data to improve the quality of care they provide to adults enrolled in Medicaid. The first year of reporting of the Medicaid Adult Core Set is FFY 2014. The TA/AS team operates a TA mailbox to respond to specific questions raised by states regarding the Core Set specifications or other technical issues. The TA/AS team also provides one-on-one assistance to states and develops TA tools, such as updates to the technical specifications, issue briefs, and webinars.

As part of the analytic support component of the program, CMS conducted a Quality Improvement (QI) 101 Workshop Series consisting of three webinars in early 2013. The goal of the series was to assist states in getting started with QI efforts; including developing aims, selecting change strategies, and teaching states how to measure and monitor improvement.

⁵⁶ The technical specifications and resource manual are available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf>.

⁵⁷ The TA/AS contract is led by Mathematica Policy Research and supported by subcontracts with the National Committee for Quality Assurance (NCQA), the Center for Health Care Strategies (CHCS), and the National Initiative for Children's Healthcare Quality (NICHQ). A fact sheet describing the TA/AS program is available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/TAFactSheet.pdf>.

Building on the QI 101 effort, the QI 201 Learning Series was launched in August 2013 with 10 teams working on a specific QIP in the area of maternal and infant health. The QI 201 series will offer monthly calls, one-on-one coaching, and affinity groups for states, based on their individual needs and goals.

E. Reporting Status

Most states have collected and analyzed Medicaid quality measures data as part of their managed care programs, including some of the Medicaid Adult Core Set measures, for many years. Standardized reporting to CMS of the Medicaid Adult Core Set measures is voluntary and a new activity for many states. CMS expects states to vary in the amount of time needed to implement collection and reporting efforts related to the measures. According to grantees' progress reports (submitted in July 2013), the 26 grantees intend to report a median of 18 measures, ranging from 15 measures in 9 states to 25 measures in 2 states.

In addition to calculating and reporting the measures, the grantees are charged with using the measures to conduct QI projects. Almost half of the grantees are conducting one or more QIPs focused on management of chronic conditions (such as diabetes care or depression medication management); others are focused on topics related to prevention and health promotion, management of acute conditions, care coordination, and availability.⁵⁸

⁵⁸ For more information on the CMS Adult Medicaid Quality Grants Program Overview, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html>.

IV. RECOMMENDATIONS

Over the past two years HHS has continued to identify and implement multifaceted ways to measure, monitor, and improve the quality of health care for adults in Medicaid. These wide-ranging efforts, including standardized measurement and implementation of quality-focused demonstration grants, are at the starting line. Bolstering these activities are investments occurring at the federal and state levels to develop capacity and infrastructure around quality measurement and improvement.

HHS acknowledges that section 1139B(b)(4) of the Social Security Act, as amended by section 2701 of the Affordable Care Act, directs the Secretary of the HHS to include in the Report to Congress any recommendations for legislative changes needed to improve the quality of care provided to adults enrolled in Medicaid, including recommendations for quality reporting by states. Many of these quality-focused activities are just beginning to build momentum, making it challenging to set forth specific recommendations at this time. We intend to monitor progress, learn from outcomes captured in standardized state reporting of the Medicaid Adult Core Set measures, and understand how to better support states in improving health care quality for adults enrolled in Medicaid.

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V. CONCLUSION

The efforts described in this Report seek to improve the quality of health care for adults enrolled in Medicaid through the simultaneous pursuit of three goals: improving the experience of care of beneficiaries and families, improving overall health for adults through targeted quality improvement strategies that cut across multiple dimensions of health, and reducing the cost of health care by efforts such as reducing medical errors and promoting appropriate care.

A range of activities is underway across state Medicaid agencies and HHS to improve the quality of health care provided to adults in Medicaid. These activities, designed to address the range of health care conditions and settings relevant to adults in Medicaid, are underway through state-initiated Medicaid 1115 waivers, Innovation Center -supported grants, and quality measurement and improvement activities. Many of the efforts are in the beginning stages, but are rapidly gaining momentum. Over the past two years, HHS implemented activities across a variety of domains of adult health care quality that do the following:

- Focus on expanding health care coverage and enrollment for adults in Medicaid. The opportunity for a person to retain consistent health care coverage will play a critical role in HHS's ability to measure and affect the quality of health care provided to these individuals.
- Underscore the critical need to support states' efforts in understanding how to design, plan, and implement quality improvement efforts. Whether through innovation awards or building state staff capacity, HHS is partnering with states to drive quality improvement.
- Emphasize that nothing can be improved, especially health care quality, if it is not measured. The first year of state reporting of the Medicaid Adult Core Set is underway. HHS will continue to provide states with technical assistance and analytic support to aid in the collection and use of these measures.

Moving forward, HHS will continue to strengthen existing partnerships and build new ones among states, HHS agencies (such as, CMS, HRSA, CDC, and SAMHSA), health care providers, and program enrollees to continue on the path toward nationally standardized quality measurement and expansion of quality improvement efforts. Among the varied efforts underway, CMS will also be focusing on aligning managed care requirements in a way that supports states in the voluntary reporting of the Medicaid Adult Core Set measures.

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APPENDIX A

**2013 CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS
ENROLLED IN MEDICAID**

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2013 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

Measure	Measure Steward	Description	Data Source
Flu Shots for Adults Ages 50 to 64	National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS)	Rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H survey was completed	Survey
Adult Body Mass Index (BMI) Assessment	NCQA/HEDIS	Percentage of Medicaid enrollees ages 18 to 74 that had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Administrative or hybrid
Breast Cancer Screening	NCQA/HEDIS	Percentage of Medicaid-enrolled women ages 42 to 69 that received a mammogram in the measurement year or the year prior to the measurement year	Administrative
Cervical Cancer Screening	NCQA/HEDIS	Percentage of Medicaid-enrolled women ages 24 to 64 that received one or more Pap tests during the measurement year or the two years prior to the measurement year	Administrative or hybrid
Medical Assistance With Smoking and Tobacco Use Cessation	NCQA/HEDIS	Rolling average represents the percentage of Medicaid enrollees age 18 and older that were current smokers or tobacco users and who received advice to quit, discussed or were recommended cessation medications, and discussed or were provided cessation methods or strategies during the measurement year	Survey
Screening for Clinical Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services (CMS)	Percentage of patients age 18 and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of the positive screen	Administrative and medical record
Plan All-Cause Readmission Rate	NCQA/HEDIS	For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	Administrative
PQI 01: Diabetes Short-Term Complications Admission Rate	Agency for Healthcare Research and Quality (AHRQ)	Number of discharges for diabetes short-term complications per 100,000 member months for Medicaid enrollees age 18 and older	Administrative
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	AHRQ	Number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older	Administrative

Appendix A (continued)

Measure	Measure Steward	Description	Data Source
PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ	Number of discharges for congestive heart failure (CHF) per 100,000 member months for Medicaid enrollees age 18 and older	Administrative
PQI 15: Asthma in Younger Adults Admission Rate	AHRQ	Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39	Administrative
Chlamydia Screening in Women Ages 21 to 24	NCQA/HEDIS	Percentage of Medicaid-enrolled women ages 21 to 24 that were identified as sexually active and that had at least one test for Chlamydia during the measurement year	Administrative
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	Percentage of discharges for Medicaid enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative
PC-01: Elective Delivery	The Joint Commission	Percentage of Medicaid- and CHIP-enrolled females with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed	Administrative and medical record
PC-03: Antenatal Steroids	The Joint Commission	Percentage of Medicaid- and CHIP-enrolled females at risk of preterm delivery with a full course of antenatal steroids completed prior to delivery of a preterm infant	Administrative and medical record
Annual HIV/AIDS Medical Visit	NCQA	Percentage of Medicaid enrollees age 18 and older with a diagnosis of HIV/AIDS and with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit	Administrative
Controlling High Blood Pressure	NCQA/HEDIS	Percentage of Medicaid enrollees ages 18 to 85 that had a diagnosis of hypertension and whose blood pressure was adequately controlled ($<140/90$) during the measurement year	Hybrid
Comprehensive Diabetes Care: LDL-C Screening	NCQA/HEDIS	Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a LDL-C screening test	Administrative or hybrid
Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA/HEDIS	Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a Hemoglobin A1c test	Administrative or hybrid
Antidepressant Medication Management	NCQA/HEDIS	Percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression, that were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) and for at least 180 days (6 months)	Administrative

Appendix A (continued)

Measure	Measure Steward	Description	Data Source
Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS	Percentage of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	Administrative
Annual Monitoring for Patients on Persistent Medications	NCQA/HEDIS	Percentage of Medicaid enrollees age 18 and older that received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and that received annual monitoring for the therapeutic agent during the measurement year	Administrative
CAHPS Health Plan Survey 5.0H – Adult Questionnaire	AHRQ NCQA/HEDIS	Survey on the experiences with care of adult Medicaid enrollees ages 18 and older	Survey
Care Transition – Transition Record Transmitted to Health Care Professional	American Medical Association/Physician Consortium for Performance Improvement (PCPI)	Percentage of Medicaid enrollees age 18 and older discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Administrative and medical record
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS	Percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who: (a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis (b) Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Administrative
Postpartum Care Rate	NCQA/HEDIS	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery	Administrative or hybrid

Source: Centers for Medicare & Medicaid Services. “Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set).” Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf>.

Note: The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.