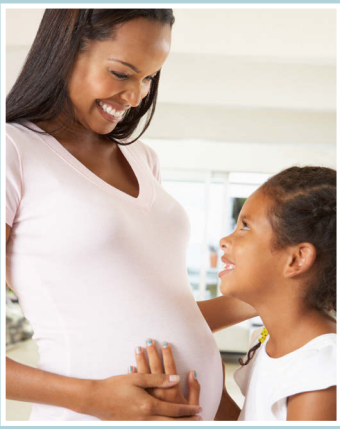

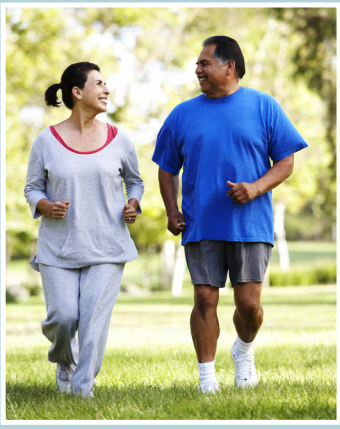

The Department of Health and Human Services

2014 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid

Health and Human Services Secretary

Sylvia Mathews Burwell

November 2014

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CONTENTS

EXECUTIVE SUMMARY vii

I INTRODUCTION 1

A. Profile of Adults Enrolled in Medicaid 1

II FEDERAL AND STATE EFFORTS RELATED TO QUALITY MEASUREMENT AND REPORTING STATEWIDE 3

A. Background on the Medicaid Adult Core Set 3

B. CMS Federal-State Data Systems for Quality Reporting 4

C. CMS Activities to Support Quality Measurement 5

1. Technical Assistance and Analytic Support Program 5

2. Adult Medicaid Quality Grant Program 5

3. Testing Experience and Functional Assessment Tools (TEFT) 6

III NATIONAL FINDINGS ON QUALITY AND ACCESS FOR ADULTS ENROLLED IN MEDICAID 7

A. Medicaid Health Plan Quality: NCQA Benchmarking Report 8

1. Methodology 8

2. Findings 9

B. Access to Care in Medicaid: Evidence from the Research Literature 10

IV MONITORING AND IMPROVING CARE IN MANAGED CARE SETTINGS 11

A. Overview 11

B. External Quality Review Technical Reports Submitted to CMS for the 2013–2014 Reporting Cycle 13

C. Reporting of Performance Measures in 2013–2014 External Quality Review Technical Reports 13

D. Description of Performance Improvement Projects in 2013–2014 14

E. Focused Review of Performance Improvement Projects 15

1. Diabetes Care 15

2. Hospital Readmissions 16

3. Emergency Department Visits 16

4. Substance Use Disorders 16

V CONCLUSION 19

APPENDIX A: 2013 CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ENROLLED IN MEDICAID

APPENDIX B: NUMBER OF MEDICAID HEALTH PLANS REPORTING HEDIS OR CAHPS MEASURES FOR ADULTS TO NCQA

APPENDIX C: GLOSSARY

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EXHIBITS

1 Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010 22

2 Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013 23

3 Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013..... 24

4 Medicaid Health Plan Performance on Selected HEDIS 2013 Measures in the Medicaid Adult Core Set..... 25

5 Change in Medicaid Health Plan Performance on Selected HEDIS Measures in the Medicaid Adult Core Set, 2011–2013 27

6 Number and Percentage of Full-Benefit Adults, Ages 21–64, Enrolled in Medicaid by State and Service Delivery Type, CY 2010* 29

7 Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2013–2014 Reporting Cycle..... 31

8 Diabetes Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle 34

9 Hospital Readmissions Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 36

10 Emergency Department (ED) Visits Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 38

11 Substance Use Disorders Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 40

A.1 2013 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid.....A.3

B.1 Number of Medicaid Health Plans Reporting HEDIS or CAHPS Measures for Adults to NCQA, by Region and State, HEDIS 2011–2013.....B.3

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), required the Secretary of the U.S. Department of Health and Human Services (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 report, required by Section 1139B of the Social Security Act, as added by Section 2701 of the Affordable Care Act, summarizes information on the quality of health care furnished to adults covered by Medicaid.

Medicaid served 32 million adults in 2010, representing about half of the beneficiaries currently enrolled in the program. Adults ages 21 to 64 accounted for 37 percent of all Medicaid enrollees and the elderly (age 65 and over) accounted for 9 percent of the total.[1] The Centers for Medicare & Medicaid Services (CMS), the HHS agency responsible for ensuring effective health care coverage for Medicaid beneficiaries, plays a key role in promoting quality health care for adults enrolled in Medicaid. CMS works collaboratively with states to strengthen systems for measuring and collecting data on access and quality.

To promote a better understanding of health care quality efforts targeting adults enrolled in Medicaid, this report discusses the status of quality measurement and reporting efforts using the Medicaid Adult Core Set and summarizes information on managed care performance measures and performance improvement projects (PIPs) reported in external quality review (EQR) technical reports submitted to CMS by states. Key findings from these information sources are summarized below.

Status of Medicaid Adult Core Set Quality Measurement and Reporting

- In federal fiscal year (FFY) 2013, 30 states reported a median of 16.5 Medicaid Adult Core Set measures.
- Eight measures were reported by at least 25 states, with the most frequently reported measures focused on diabetes care management, postpartum care visits, mental health treatment, and women's preventive health care.
- Since this was the first year of state reporting on the Medicaid Adult Core Set measures, CMS is not publicly reporting findings on the measures but using the data as an opportunity to learn about the challenges states faced in uniformly reporting the measures. The findings will also be used to improve guidance for reporting that CMS provides to states.
- Medicaid health plan performance was highest on measures focused on diabetes care and medication management and lowest on measures related to behavioral health care access and use. Analysis of National Committee for Quality Assurance benchmarking data was conducted to determine these findings.

[1] Mathematica analysis of 2010 Medicaid Analytic eXtract data. Includes full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only).

Managed Care External Quality Review Findings

- Of the 42 states that currently contract with managed care plans, 39 submitted EQR technical reports to CMS for the 2013–2014 reporting cycle. The most frequently reported adult performance measures in the EQR reports are similar to those in the Medicaid Adult Core Set.
- Through their managed care entities, states are engaged in various types of improvement projects for adults. This report profiles PIPs in four areas: (1) adults with diabetes, (2) hospital readmissions, (3) hospital emergency department (ED) visits, and (4) substance use disorders.
- During this reporting cycle, 17 states reported a total of 62 adult diabetes PIPs, 14 states reported a total of 93 PIPs aimed at reducing hospital readmissions, 14 states reported 81 PIPs aimed at reducing hospital ED visits, and 5 states reported 22 PIPs with a focus on improving care for substance use disorders.

Conclusion

This report documents the foundation developed by CMS and states for measuring and improving the quality of health care for adults enrolled in Medicaid, irrespective of the delivery system in which they receive their health care. CMS plans to publicly report Medicaid Adult Core Set state-specific data in the 2015 Secretary's Report. These data will support CMS's future goals to: (1) increase the number of states reporting on the Medicaid Adult Core Set measures, (2) increase the number of measures reported by each state, (3) improve the completeness of the data reported, and (4) use the measures as part of state quality improvement initiatives, including for managed care EQR PIPs.

CMS and states will continue to work together to measure performance and use data collected to drive improvements in the quality of health care. As the momentum to pay for value rather than volume of services grows, state-specific performance data will be critical in guiding efforts to transform the systems of care that provide services to Medicaid enrollees.

I. INTRODUCTION

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), established the National Quality Strategy for Quality Improvement in Health Care (National Quality Strategy), which serves as the national blueprint to improve the health care delivery system and health outcomes by pursuing three goals: better care, healthy people/healthy communities, and affordable care.[2] These three goals are reflected in the activities undertaken by the Centers for Medicare & Medicaid Services (CMS) and other agencies of the U.S. Department of Health and Human Services (HHS) to improve care for adults enrolled in Medicaid.

The Affordable Care Act also 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. As required by section 1139B of the Social Security Act (as added by section 2701 of the Affordable Care Act), this report summarizes the status of state annual reporting on:

- a core set of health care quality measures for adults enrolled in Medicaid, and
- the quality of health care furnished to adults covered by Medicaid, including information collected through external quality reviews of managed care organizations (MCOs).

The HHS Secretary is required to "collect, analyze, and make publicly available the information reported by States" by September 30, 2014, and annually thereafter.[3] This is the Secretary's first annual report on the quality of health care for adults enrolled in Medicaid, and complements the Secretary's report on the quality of care for children in Medicaid and the Children's Health Insurance Program (CHIP), which has been published annually since 2010.[4]

A. Profile of Adults Enrolled in Medicaid

Of the 69 million Medicaid enrollees in 2010, about half (32 million) were adults ages 21 and older. [5] Adults ages 21 to 64 accounted for 37 percent of all Medicaid enrollees and the elderly (ages 65 and over) accounted for 9 percent of all enrollees (Exhibit 1).

Medicaid and CHIP are also critically important for population subgroups that disproportionately have lower-incomes, including racial and ethnic minority groups, people with limited English proficiency (LEP), and people who have historically suffered disparate health care access and health outcomes (e.g., rural population groups, women with young children). Women in their

[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(d)(2) of the Social Security Act (42 U.S.C. §1320b-9b(d)(2)). Available at: http://www.ssa.gov/OP_Home/ssact/title11/1139B.htm.

[4] Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

[5] Mathematica analysis of 2010 Medicaid Analytic eXtract data. Includes full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only).

reproductive years (ages 18 to 44) comprise a sizable share of adult Medicaid enrollees.[6] For this group, Medicaid provides coverage for a range of services including preventive services such as pap smears and mammography, family planning, and pregnancy-related services. Medicaid financed nearly 48 percent of all births in the United States in 2010, ranging from 24 percent of births in Hawaii to 69 percent of births in Louisiana.[7]

Medicaid also provides coverage for low-income people with disabilities and/or who are elderly, as well as supplemental coverage for Medicare enrollees (often called dually eligible beneficiaries). In 2010, about 12 percent (7.2 million) full-benefit, non-elderly adults with disabilities were enrolled in Medicaid (Exhibit 1). People with disabilities are a heterogeneous group, consisting of individuals with physical, mental, and intellectual impairments. Both the dually eligible and people with disabilities have complex health care needs and are high users of long-term services and supports.[8]

Adults covered by Medicaid generally are in poorer health than privately insured adults with similar income.[9] Analysis of 2003 to 2009 data from the Medical Expenditure Panel Survey found that, low-income adults ages 19 to 64 covered by Medicaid, compared with privately insured adults had statistically significantly higher rates of (1) an activity limitation during the year (53 percent versus 21 percent), (2) more than one chronic condition (48 percent versus 32 percent), and (3) self-reported fair or poor mental health (26 percent versus 7 percent).

Medicaid spending on services varies substantially across subsets of adult Medicaid enrollees, due in part to differences in the need for services. In 2012, average Medicaid spending per full-year equivalent enrollee was $4,100 for adults without disabilities, $17,300 for non-elderly people with disabilities, and $15,700 for the elderly.[10]

The Affordable Care Act established new health coverage options for Americans, including the expansion of Medicaid eligibility to low-income individuals such as adults without dependent children. Coverage expansions, combined with the changing demographics of our country, create an even more urgent need for robust quality measurement programs to better understand and address the health needs of new and historically served Medicaid population groups.

In sum, adult Medicaid enrollees have diverse health care needs. As a result, HHS's efforts to measure and improve the quality of health care provided to adults enrolled in Medicaid are designed to address these diverse needs.

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[6] Kaiser Family Foundation. "Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act." Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7213-04.pdf.

[7] Markus, A.R., et al. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues, vol. 23, no. 5, 2013, pp. e273–e280.

[8] Kaiser Family Foundation. "State Health Facts: Dual Eligibles." Available at: http://kff.org/state-category/medicare/dual-eligibles/.

[9] Coughlin, T. et al. "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults." Kaiser Family Foundation, May 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf.

[10] U.S. Department of Health and Human Services. "2013 Actuarial Report on the Financial Outlook for Medicaid," Table 2. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf.

II. FEDERAL AND STATE EFFORTS RELATED TO QUALITY MEASUREMENT AND REPORTING STATEWIDE

Section 1139B of the Social Security Act, as added by section 2701 of the Affordable Care Act, requires the Secretary to identify and publish a core set of health care quality measures for adults enrolled in Medicaid (Medicaid Adult Core Set). State reporting of the Medicaid Adult Core Set is voluntary, similar to the Core Set of Children's Health Care Quality Measures (of which states just completed their fourth year of reporting).[11]

A. Background on the Medicaid Adult Core Set

In January 2012, CMS published the Medicaid Adult Core Set (see Appendix A).[12] The initial core set of 26 health care quality measures was identified in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ's) National Advisory Council. This multi-stakeholder group composed of state Medicaid representatives, health care quality experts, representatives of health professional organizations, and patient advocacy groups, reviewed and evaluated approximately 1,000 measures from nationally recognized sources. The subcommittee broke into four work groups to focus on four dimensions of health care: adult health, maternal/ reproductive health, complex health care needs, and mental health and substance use. Following extensive 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 legislation further requires that improvements to the initial core set of adult health care quality measures be issued annually beginning in January 2014. To meet this requirement, CMS worked with the National Quality Forum's (NQF's) Measure Applications Partnership (MAP) to conduct an expedited review of the Medicaid Adult Core Set in September 2013. The objectives of this review were to understand states' experience to date with collecting the Medicaid Adult Core Set measures, evaluate the Medicaid Adult Core Set against the MAP measurement criteria, and consider measure alignment opportunities and identify measure gaps. After reviewing MAP recommendations and potential updates through CMS's internal measurement review process, CMS replaced one measure, Annual HIV/AIDS Medical Visit, with HIV Viral Load Suppression in the 2014 Medicaid Adult Core Set.[13]

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[11] State performance on the Child Core Set measures is publicly reported in the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP. The Report also contains finding on quality of care provided to pregnant women. The report is available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf.

[12] "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: http://www.gpo.gov/fdsys/pkg/FR-2012-01-04/pdf/2011-33756.pdf.

[13] The 2014 Medicaid Adult Core Set is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultCoreMeasures.pdf. For further information on the 2014 Medicaid Adult Core Set, see http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

The multi-stakeholder review of the 2014 Medicaid Adult Core Set is nearly complete. The NQF Medicaid Adult Task Force began meeting in spring to review the 2014 Medicaid Adult Core Set.[14] CMS will release updates to the 2015 Medicaid Adult Core Set based on the multi-stakeholder review feedback and after completing its internal measurement review process, by January 2015.

CMS views the annual updating process 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 its measurement development efforts around managed long-term services and supports (LTSS) and the Health Home Program, as well as filling other key gap areas, such as measures for care coordination and patient-reported outcomes.

To address one of these gap areas, in the fall of 2014, CMS will be conducting the first ever nationwide Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of adult Medicaid enrollees to obtain national and state-by-state measures of access, barriers to care, and satisfaction with care across financing and delivery models.[15] This survey, which is a modified version of the Adult CAHPS Medicaid 5.0H questionnaire, will be administered in both English and Spanish. It will collect baseline information on the experiences of low-income adults during the early stages of implementation of the Affordable Care Act and will be used to inform CMS and state efforts to improve health care delivery for Medicaid enrollees.[16]

B. CMS Federal-State Data Systems for Quality Reporting

Section 1139B of the Social Security Act, as added by the Affordable Care Act, requires the Secretary 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 Medicaid/CHIP quality reporting and performance measurement.

In the interim, CMS is using the CARTS system 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 and Adult Core Set measures, and will serve as the tool states use to report the Health Home Core Set measures beginning in FFY 2015. CMS believes that standardized reporting has the potential to strengthen quality reporting, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for adults in Medicaid.

[14] http://www.qualityforum.org/MAP_Task_Forces.aspx.

[15] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[16] Nationwide CAHPS Survey of Adult Medicaid Enrollees. June 6, 2014. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CAHPS-Survey-of-Adult-Medicaid-Enrollees.pdf

C. CMS Activities to Support Quality Measurement

1. Technical Assistance and Analytic Support Program

To encourage and support states to report the Medicaid Adult Core Set measures, CMS implemented a Technical Assistance and Analytic Support (TA/AS) Program.[17] 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 support state efforts to use these data to improve the quality of care. As part of this program, 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 has developed TA tools, such as a resource manual and technical specifications, issue briefs, and webinars. In the first year, the TA/AS team responded to more than 140 TA requests on the Medicaid Adult Core Set measures, from 33 states.

2. Adult Medicaid Quality Grant Program

To assist states in collecting and reporting the Medicaid Adult Core Set, CMS launched the Adult Medicaid Quality Grant Program in December 2012. Funded by the Affordable Care Act, CMS selected 26 states to participate in the two-year grant program.[18] 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 quality improvement projects (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).

The grant program is assisting CMS in understanding the value and potential issues in collecting data on Medicaid Adult Core Set measures, as grantees are evaluating the collection and reporting of these measures and sharing feedback with CMS. The primary mechanism for these activities is a series of monthly meetings between grantees, CMS staff, and the TA/AS Program. Additionally, to help further the understanding of how health care quality affects diverse

[17] The TA/AS contract is led by Mathematica Policy Research and supported by subcontracts with the National Committee for Quality Assurance (NCQA) and the Center for Health Care Strategies (CHCS). 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.

[18] 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. Texas withdrew from the second year of the grant program. For more information on the Adult Medicaid Quality Grant Program see: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html.

populations within Medicaid, states were asked to collect data and stratify at least three of four specified measures (Comprehensive Diabetes Care: Hemoglobin A1c Testing, Postpartum Care, Controlling High Blood Pressure, or Cervical Cancer Screening) by at least two demographic categories: race, ethnicity, gender, language, geography, and disability status.

3. Testing Experience and Functional Assessment Tools (TEFT)

Beneficiaries using community-based long-term services and supports (CB-LTSS) are another focus of improved measurement and quality improvement efforts at CMS. The Testing Experience and Functional Assessment Tools (TEFT) grant program focuses on leveraging innovation in health information technology by testing quality measurement tools and demonstrating e-health in Medicaid CB-LTSS for the first time at a national scale. In March 2014, CMS selected nine states to receive grants to enable them to (1) test and evaluate new measures of functional capacity and individual experience for populations receiving CB-LTSS, (2) identify and harmonize the use of health information technology, and (3) identify and harmonize electronic CB-LTSS standards. As part of this demonstration project, TEFT grantees will field test an experience survey and a modified set of Continuity Assessment Record and Evaluation (CARE) functional assessment measures, demonstrate use of personal health records, and create an electronic CB-LTSS record. The TEFT grant program will provide national measures and valuable feedback on how health information technology can be implemented in this component of the Medicaid system.[19]

[19] The states are Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, Minnesota, and New Hampshire. 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. For more information on the TEFT grant program, see: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html.

III. NATIONAL FINDINGS ON QUALITY AND ACCESS FOR ADULTS ENROLLED IN MEDICAID

Beginning in 2014, states voluntarily collected and reported data on the Medicaid Adult Core Set measures. Thirty states reported one or more of the measures for the FFY 2013 reporting year (Exhibit 2). Twenty-six of the 30 states were Adult Medicaid Quality Grant Program grantees and 4 states were non-grantees. States reported a median of 16.5 measures.

Eight measures were reported by at least 25 states, an encouraging start for the first year of voluntary reporting (Exhibit 3). The most frequently reported measures were focused on (1) diabetes care management (LDL screening and hemoglobin A1c testing); (2) women's preventive health care (cervical cancer screening, breast cancer screening, and Chlamydia screening); (3) postpartum care visits; and (4) mental health treatment (follow-up after hospitalization for mental illness and antidepressant medication management). All of these measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS®), and are frequently included in Medicaid managed care contracts for monitoring the quality of care provided to Medicaid enrollees receiving care through MCOs.[20] In addition, these measures are calculated primarily using Medicaid administrative data and do not require medical record review.

Reasons for not reporting the Core Set measures vary by state. The least frequently reported measures include those that require states to conduct medical record review in order to collect the necessary data. These reviews can be resource intensive for states to conduct, and there are sometimes legal or technical barriers to collecting data from hospitals or individual providers. Of the 3 measures reported by fewer than 10 states (i.e., antenatal steroids, screening for clinical depression and follow-up, and care transition), data access and technical capacity were among the most often cited reasons for states not reporting on the measures.

CMS views the first year of reporting of the Medicaid Adult Core Set as an opportunity for learning and refinement of the Core Set measures. CMS is using the data reported by states to better understand the states' abilities (and challenges) to collect and report the measures. CMS plans to publicly report Medicaid Adult Core Set data in the 2015 Secretary's Report. As CMS moves into the second year of reporting, it will strive to meet four goals:

- Increase the number of states reporting on the Medicaid Adult Core Set measures
- Increase the number of measures reported by each state
- Improve the completeness of the data reported
- Use the measures as part of state quality improvement initiatives, including for managed care external quality review performance improvement projects

[20] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

A. Medicaid Health Plan Quality: NCQA Benchmarking Report

Seventeen of the 26 measures in the Medicaid Adult Core Set are Healthcare Effectiveness Data and Information Set (HEDIS) measures. Since CMS has decided to forgo public reporting of data submitted by states during the first year of collecting data on the Adult Core Set measures, this report includes performance data on measures in the Core Set reported to the National Committee for Quality Assurance (NCQA) by health plans providing services to Medicaid enrollees.[21]

In 2013, 213 Medicaid health plans in 37 states submitted performance data on Medicaid enrollees to the NCQA national database (Appendix B).[22] The health plan data reported to NCQA reflect a subset of the performance data in which states are reporting to CMS on the Medicaid Adult Core Set measures. States are asked to collect data on Core Set measures for enrollees of all delivery system types, including managed care and fee-for-service.

1. Methodology

Means, medians, and 25th and 75th percentiles were calculated from NCQA's HEDIS database for measures included in the 2013 Medicaid Adult Core Set. The data include performance measures submitted by health plans for HEDIS 2011 to 2013 based on services delivered in calendar years 2010 through 2012, respectively.[23] HEDIS data are reported to NCQA by product line (commercial, Medicaid, and Medicare) and lines of business (health maintenance organization [HMO] or preferred provider organization [PPO] plans). The data in this report include HMO results for both Medicaid and commercial product lines. Within the HEDIS database, HMO plans include HMOs, point-of-service (POS), and HMO/POS/PPO combination plans. (Standalone PPO plans are excluded from this analysis because this model is not used in the Medicaid program.)

Comparison over time provides an assessment of the direction and magnitude of the performance trend. A Wilcoxon Rank Sum Test was performed to test statistical significance. Numbers indicate statistically significant changes in median performance; 'NS' is used to denote no statistically significant change in median performance. The trend analysis is based on health plan submitted data, which do not necessarily include the same measures submitted by the same plans over the three-year period.

[21] Health plans submit their audited results to NCQA in June of each year for the previous calendar year. For example, HEDIS 2013 data reflect services delivered during measurement year 2012. All HEDIS data submitted to NCQA must undergo a HEDIS Compliance Audit to ensure adherence to HEDIS specifications and the processes used to calculate measure results.

[22] These plans covered an estimated 27.3 million child and adult Medicaid enrollees in 2013. Data are not separately available on the number of Medicaid health plan enrollees who are adults. For additional information, see Benchmarks for Medicaid Adult Health Care Quality Measures at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultBenchmarkReport.pdf.

[23] The HEDIS nomenclature follows the reporting year. The measurement year is the year prior to the reporting year. For example, HEDIS 2013 includes measure results that were reported in June 2013. These results primarily assess health plan performance in calendar year 2012.

2. Findings

The number of plans reporting on each individual HEDIS measure varies due to (1) patient populations served (for example, plans may not have sufficient numbers of patients who meet demographic and diagnosis criteria for reliable and valid reporting of specific measures), (2) state contractual requirements for reporting HEDIS measures, and (3) whether the measure is required for NCQA accreditation.

Exhibit 4 shows Medicaid health plan performance on selected HEDIS 2013 measures included in the Medicaid Adult Core Set. Median Medicaid health plan performance was highest on the following three measures:

- Comprehensive Diabetes Care:
  - LDL-C Screening (76 percent); and
  - Hemoglobin A1c Testing (83 percent)
- Annual Monitoring of Patients on Persistent Medications: composite measure (85 percent) and individual measures of ACE inhibitors/ARBs (87 percent), digoxin (91 percent), and diuretic (87 percent)

Performance was mixed on the Smoking and Tobacco Cessation measure. The median rate was higher on the general guidance component and lower on the two components related to specific cessation strategies:

- Advising Smokers and Tobacco Users to Quit (76 percent)
- Medical Assistance With Smoking and Tobacco Use Cessation:
  - Discussing cessation medications (45 percent); and
  - Discussing cessation strategies (40 percent)

Performance was lowest on the following measures, all related to indicators of effective behavioral health care services:

- Follow-Up After Hospitalization for Mental Illness: follow-up within 7 days of discharge (45 percent)
- Antidepressant Medication Management: effective continuation phase treatment (35 percent)
- Alcohol and Other Drug (AOD) Dependence Treatment: initiation of AOD treatment (39 percent) and engagement of AOD treatment (9 percent)

CAHPS 5.0H measures of patient experience with health plans and providers are also collected by NCQA as part of its accreditation program. As shown in Exhibit 4, the CAHPS measures with the highest median rating among Medicaid enrollees in health plans were:

- How well doctors communicate (72 percent)
- Customer service (67 percent)

- Rating of specialist seen most often (64 percent)
- Rating of personal doctor (63 percent)

The two CAHPS measures with the lowest median ratings were for health promotion and education (28 percent), shared decision-making (51 percent), and rating of all health care (51 percent).

Between HEDIS 2011 and HEDIS 2013, median Medicaid health plan scores did not change substantially, with two exceptions: (1) the CAHPS measure for customer service increased by nearly 9 percentage points from 59 percent to 67 percent; and (2) performance on Adult Body Mass Index (BMI) Assessment increased by 24 percentage points from 48 percent to 72 percent (Exhibit 5). However, the change in the BMI Assessment rate was due in part to a shift from administrative to hybrid data collection methods to improve the accuracy of this measure.

B. Access to Care in Medicaid: Evidence from the Research Literature

Analysis of data from the 2003 to 2009 Medical Expenditure Panel Survey (MEPS), a nationally representative survey, found that most adults ages 18 to 64 covered by Medicaid report access to care that is fairly comparable to that of low-income Americans with employer-sponsored insurance (ESI).[24] Most Medicaid-enrolled adults reported having a usual source of care (84 percent) and a relatively small share reported having unmet medical needs (5 percent) or an unmet need for prescription drugs (4 percent). There were two indicators from the analysis of the 2003–2009 MEPS that warrant improvement: Medicaid enrollees compared to individuals with ESI had a higher likelihood of using emergency department services (26 percent versus 21 percent) and a lower likelihood of a specialty care visit (27 percent versus 54 percent).

[24] Coughlin, T. et al. "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults. " Kaiser Family Foundation, May 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf.

IV. MONITORING AND IMPROVING CARE IN MANAGED CARE SETTINGS

In 2010, 61 percent of adults enrolled in Medicaid, ages 21 to 64, obtained their health care through managed care plans (Exhibit 6). The rate of managed care enrollment varied widely across state Medicaid programs, with 16 states reporting 0 percent of adults enrolled in managed care to 100 percent of adults in Tennessee enrolled in managed care. States using a managed care delivery system must comply with certain federal requirements, including standards related to assessing and monitoring the quality of care provided by contracted managed care plans. This chapter of the report summarizes state activities related to monitoring and improving the quality of care for adults enrolled in managed care.

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states opting to use managed care for the delivery of health care in Medicaid.[25] Federal regulations implemented in 2003 require states to perform an annual external quality review (EQR) for each contracted managed care organization (MCO), prepaid inpatient health plan (PIHP), and health insuring organization (HIO).[26] These annual EQRs analyze and evaluate information on quality, timeliness, and access to the health care services that an MCO, PIHP, or HIO, and their contractors, furnish to Medicaid beneficiaries. Section 1139B(d) of the Social Security Act, as amended by section 2701 of the Affordable Care Act, requires the Secretary to include in this annual report the information that states collect through EQRs of MCOs and PIHPs participating in Medicaid.[27]

Federal managed care regulations at 42 CFR 438.310 et seq. lay out the parameters for conducting an EQR, including state responsibilities, qualifications of an external quality review organization (EQRO), federal financial participation, and state deliverable requirements. Per regulation, the state, its agent (not an MCO or PIHP), or an EQRO must perform three EQR-related activities:

[25] Codified at Section 1932(c) of the Social Security Act.

[26] See 42 CFR 438.2 for full definitions of MCO, PIHP, and HIO. HIOs are treated as MCOs for purposes of this analysis.

[27] Section 1139B(d) of the Social Security Act also requires the reporting of state-specific information on the quality of health care furnished to adults in benchmark plans under Section 1937 of the Act. There are currently no separate state reporting requirements for benchmark plans other than the EQR reporting process required for states contracting with MCOs and PIHPs. In other words, state EQR technical reports must include information related to benchmark plans that deliver care through MCOs or PIHPs; however, because this information is reported in the aggregate, which is allowable under EQR requirements, detailed data are not available for benchmark plans.

1. Validation[28] of performance measures[29]
2. Validation of performance improvement projects (PIPs)[30]
3. A review, at least every three years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement[31]

The state may choose to perform up to five additional EQR-related activities.[32] A statutorily required set of CMS EQR Protocols provide instruction to states and EQROs on the process for conducting each of the eight EQR-related activities.[33] The state must contract with a qualified EQRO to produce an annual technical report that uses information from the EQR-related activities to assess the quality, timeliness, and access to care provided by each MCO and PIHP. The EQR technical report must also include an assessment of strengths and weaknesses with respect to quality, access, and timeliness and set forth recommendations for improving the quality of health care services furnished by each MCO or PIHP. Per regulation, the EQR technical report is a public document, available upon request to all interested parties.[34] Annually, CMS reviews each state's EQR technical report(s) for evaluation and follow-up.

[28] 42 CFR 438.320 defines validation as the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

[29] In accordance with 42 CFR 438.240(c), managed care states must require each MCO and PIHP to annually measure and report to the state its performance using standard measures required by the state. States are then required to annually ensure that performance measures reported by the MCO or PIHP during the preceding 12 months are validated.

[30] In accordance with 42 CFR 438.240(d), managed care states must require each MCO and PIHP to have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. States are then required to annually ensure that any MCO or PIHP performance improvement projects underway during the preceding 12 months are validated.

[31] 42 CFR §438.358(b)(3).

[32] Refer to 42 CFR 438.358(c) for a comprehensive list of optional EQR-related activities.

[33] In October 2012, CMS revised the EQR Protocols for the purpose of standardizing and strengthening managed care quality monitoring and improvement activities in Medicaid. The CMS EQR Protocols are available under "Technical Assistance Documents" at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[34] See 42 C.F.R. § 438.364. EQR technical reports submitted to CMS and currently posted on State Medicaid web sites: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html.

B. External Quality Review Technical Reports Submitted to CMS for the 2013–2014 Reporting Cycle

Of the 42 states[35] that contracted with MCOs or PIHPs during the 2013–2014 reporting cycle, 39 states submitted EQR technical reports to CMS that provided information on the care furnished to adults covered by Medicaid.[36] These states contracted with 17 different EQROs to conduct the annual EQR, and six EQROs conducted reviews for multiple states during the 2013–2014 reporting cycle.[37] The majority of EQR technical reports focused on physical health services, but some included information on other types of managed care services, such as LTSS or behavioral health.

The 2013–2014 EQR technical reports provide insight into the strategies and efforts that states use to improve the quality of care for adults in Medicaid. The reports indicate that states and managed care entities engage in a variety of quality measurement and improvement efforts. Generally, the scope and focus of state initiatives are based on several factors, including the populations served by managed care, stakeholder and beneficiary feedback, and clinical areas in need of improvement.

EQR technical reports varied considerably in their structure, level of detail, and focus on quality, access, and timeliness of care. For example, some EQR technical reports contained a detailed analysis of how specific measurement and improvement efforts interface with state monitoring of quality, access, and timeliness of care. Other EQR technical reports did not explicitly discuss quality, access, and timeliness at all. Some provided substantial details related to the performance measure and PIP validation process, PIP interventions, and performance outcomes. This lack of uniformity across EQR technical reports is partly due to differences in state interpretation of regulatory language. While current regulations require states to annually validate performance measures and PIPs, they do not specifically require the inclusion of details on outcomes or interventions in the EQR technical reports. Despite this, the level of detail presented in the EQR technical reports has become more comprehensive over the past few years, following intensive CMS outreach and technical assistance efforts to that effect.

C. Reporting of Performance Measures in 2013–2014 External Quality Review Technical Reports

Of the 39 states that submitted EQR technical reports for the 2013–2014 reporting cycle, all states except two identified the types of performance measures reported by MCOs and PIHPs, and all states except D.C., North Carolina, and South Carolina identified the performance measures that were also validated by the EQRO.

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[35] For purposes of EQR, the term "states" includes the 50 states, the District of Columbia, and the territories.

[36] Utah and New Hampshire did not submit EQR reports before May 16, 2014, for inclusion in this analysis. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2013-2014 reporting cycle; therefore, North Dakota's EQR technical report is not included in this analysis. Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll adults covered by Medicaid.

[37] For a list of EQROs with current state Medicaid contracts in 2014, see Table EQR 1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2013-2014.zip.

The most frequently reported performance measures for adults focused on diabetes care, behavioral health,[38] and asthma/COPD.[39] Other examples of performance measures states collected include those related to cardiac care, access to preventive/ambulatory services, and cervical and breast cancer screening. Many of the performance measures overlapped with measures from both the CMS Medicaid Adult Core Set and 2013 HEDIS, though the use of these measure sets is not required by CMS.

In the 2013–2014 reporting cycle:

- While 33 of the 39 states chose to include the performance rates achieved by each MCO or PIHP, only some provided additional information on the context for the performance rates achieved by the MCO or PIHP, as well as suggestions for improving future performance.
- Several states separated out the performance rates by subpopulations within their state. For example, Colorado and Iowa reported performance measure rates separately for their physical health and behavioral health programs while Florida and New York included performance rates for different geographic regions within the state.
- Thirty-one states compared performance in the 2013–2014 reporting cycle to performance in previous years. Twenty-one states also compared MCO and PIHP performance to national HEDIS Medicaid rates and 17 states included statewide managed care performance rates.

D. Description of Performance Improvement Projects in 2013–2014

All states that submitted an EQR technical report for the 2013–2014 reporting cycle included at least one PIP specific to the adult population and 38 of the 39 states included information on validation, as required by regulation.[40] Among these states, the topical focus and the number of PIPs per state varied considerably (Exhibit 7). Of the PIPs focused on the adult population, there were 147 PIPs related to behavioral health (19 states), 81 PIPs related to emergency department visits (14 states), 62 PIPs related to diabetes care (17 states), and 93 PIPs related to hospital readmissions (14 states). While most states conducted 20 or fewer PIPs during the reporting cycle, eight states had more than 20 PIPs. Texas, Florida, and California—states with large Medicaid managed care populations and a large number of MCOs and PIHPs—conducted the largest number of PIPs at 92, 87, and 79 PIPs, respectively.

Sixteen state EQR technical reports identified that the state either mandated a PIP topic or required its MCOs or PIHPs to participate in a collaborative PIP.[41] For example, four states

[38] Behavioral health performance measures include the subtopics of substance use disorders.

[39] Specific information related to state reported performance measures for adults can be found on Table EQR3 at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2013-2014.zip.

[40] Oregon's EQRO did not validate any PIPs for this reporting cycle because the state's Coordinated Care Organizations (CCOs) were in their first year of operation; the technical report instead provided information on the PIPs in development and outlined a protocol for validating PIPs in the next reporting cycle.

[41] States that mandated PIP topics for MCOs or PIHPs include: Arizona, California, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Michigan, Nevada, Oregon, Pennsylvania, Rhode Island, Washington, and West Virginia.

(Florida, Maryland, Michigan, and Pennsylvania) mandated implementation of a PIP related to behavioral health. Other state-mandated PIP topics included: diabetes care, emergency department visits, hospital readmissions, Chlamydia screening for women, and use of imaging studies for low back pain. There were also a number of administrative PIPs, focusing on such topics as balance billing or call center timeliness.[42]

As mentioned previously, some EQR technical reports provided detailed intervention and outcomes information related to each PIP, as well as EQRO recommendations for improvement. Of the profiled PIP topics, education and outreach for members, providers, and communities were the most common interventions. Discussions of EQRO findings on the performance, progress, and limitations of each PIP differed greatly across reports, with descriptions of PIPs occasionally lacking key details. This lack of detailed intervention and outcomes information within the EQR technical reports has limited CMS's ability to conduct a comprehensive assessment on the efficacy of state quality improvement efforts for adults enrolled in managed care.

E. Focused Review of Performance Improvement Projects

This section presents findings from detailed abstractions of EQRO reporting on PIPs in four areas in which improvements in care could result in better health outcomes and lower cost: (1) care for adults with diabetes, (2) adult hospital readmissions, (3) adult emergency department visits, and (4) treatment of adults with substance use disorders.[43] An example of a state PIP is provided for each priority topic area. Criteria for selecting states to highlight below included whether the EQR technical report contained some information on interventions and outcomes, and an interest in ensuring geographic diversity of the states profiled.

1. Diabetes Care

Seventeen states reported a combined total of 62 adult diabetes PIPs during this reporting cycle (Exhibit 8). While the interventions of each PIP varied, common improvement aims included: controlling HbA1c (a measure of blood sugar), LDL-C (a measure of cholesterol), and/or blood pressure; increasing the percentage of members who had a diabetic retinal eye exam; and improving medication management.

Hawaii was one state in which all seven MCOs participated in PIPs aimed at improving care for members with diabetes.[44] The target indicators differed slightly by MCO, but included: (1) retinal eye exams for members with diabetes, (2) blood pressure, (3) HbA1c, and (4) LDL-C screening and control for members with diabetes. Interventions included: (1) mailing educational materials on diabetes to members to generate interest in disease management programs, (2)

[42] These administrative PIPs are reflected in the "other" column in Exhibit 7.

[43] Quality improvement efforts related to pregnant women are profiled in the "2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP" available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf. Additional information on "Adult Findings from EQR Technical Reports, 2013-2014" is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2013-2014.zip.

[44] Five of the seven MCOs were not yet in the re-measurement phase for the diabetes care PIPs.

provider and staff education and distribution of HEDIS toolkits, (3) the introduction of a care gap program, and (4) a pay-for-performance program for providers. The EQRO recommended that, in order to improve PIP performance, MCOs should have processes in place for conducting annual evaluations of the effectiveness of each intervention implemented, as well as annual barrier and drill-down analyses. Results varied by performance measure and MCO. In three of the seven HMOs, there was improvement on at least one measure.

2. Hospital Readmissions

Fourteen states reported a combined total of 93 PIPs aimed at reducing adult hospital readmissions during this reporting cycle (Exhibit 9). In three of those states, California, Hawaii, and Arizona, hospital readmissions PIPs were mandated for all health plans. Interventions often focused on implementing discharge planning and transitional care activities such as appointment reminder calls and mailings after discharge to ensure members' post-discharge needs were met.

Missouri had one PIP that was particularly successful in reducing member hospital readmissions at both 30 days and 90 days by two percent in 2011 and five percent in 2012. The PIP employed three major interventions: (1) the development and implementation of a disease management program for frequent causes of readmissions, including asthma and diabetes, (2) enhancement of a case management process to prevent readmissions, and (3) the development of an asthma home health program. The EQRO noted that the interventions implemented under this PIP were generally system wide and part of regular MCO operations, indicating that the improvements in hospital readmissions should continue in future years.

3. Emergency Department Visits

Fourteen states reported a combined total of 81 PIPs focused on reducing inappropriate use of the emergency department during this reporting cycle (Exhibit 10). Reducing the rate of avoidable emergency department utilization and increasing the rate of emergency department visits that do not result in an inpatient stay were the mostly frequently reported improvement aims in this area.

Louisiana required its three MCOs to conduct a PIP aimed at decreasing emergency department utilization, using the HEDIS Emergency Department Visits/1,000 Member Months measure as the target indicator. Each MCO set its own specific goals and designed its own interventions targeted to different stakeholders including members, providers, and the community. Interventions included (1) case management for "frequent flyers," (2) outreach calls to members, (3) mailing of educational materials, (4) quarterly emergency department reports for providers, and (5) outreach to high-volume hospital emergency department case management staff. While some performance data is available for all three MCOs, the EQRO recommended caution when interpreting the data for several reasons, including the structuring of the baseline and remeasurement periods. The EQRO identified the selection of interventions targeting both members and providers as a strength for all MCOs.

4. Substance Use Disorders

Nineteen states reported a combined total of 147 PIPs focused on behavioral health topics (Exhibit 11). These PIPs included improvement aims related to follow-up after hospitalization for a behavioral health or mental health diagnosis, depression care, and management of

antipsychotics. One of the most common topics within the broader category of behavioral health was substance use disorders, which was the focus of 27 PIPs in seven states (Arizona, California, Kentucky, Maryland, Massachusetts, New York, and Wisconsin).

Beginning in 2009 and continuing through this reporting cycle, Maryland required each of its seven MCOs to conduct a PIP aimed at increasing both the initiation of, and engagement in, alcohol and other drug dependence treatment.[45] The MCOs implemented a variety of interventions, including (1) the addition of a substance use consultant/Medical Director to conduct peer-to-peer discussions with providers, (2) engagement of pregnant members in group or individual counseling, (3) implementation of patient-centered medical homes, (4) revision of substance use provider contracts, and (5) improvements to information systems to better coordinate substance use care across settings. Performance, however, was mixed: across all MCOs, performance on the initiation of alcohol and other drug dependence treatment indicator declined by 5.6 percentage points, and performance on the engagement of alcohol and other drug dependence treatment indicator improved by 1.5 percentage points.[46]

[45] Both indicators were according to HEDIS measure specifications.

[46] The EQRO noted that the national HEDIS Medicaid rate for both of these measures declined during this time period. The EQRO also stated that Medicaid members who received substance use disorder treatment that is billed through a behavioral health entity, paid for by a grant or with cash, or received from a provider outside the Medicaid network would not be counted in the target HEDIS measures for these PIPs, which could be a factor in the lack of improvement on the initiation measure.

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V. CONCLUSION

This report documents the foundation developed by CMS and states for measuring and improving the quality of care for adults enrolled in Medicaid, whether they obtain services through fee-for-service or a managed care setting. Using the resources and the authorities of the Affordable Care Act, CMS has supported state efforts to report standardized quality metrics on adults covered by Medicaid.

During the first year of reporting on the Medicaid Adult Core Set, 30 states reported a median of 16.5 measures for FFY 2013. The Adult Medicaid Quality Grant Program has been instrumental in building state capacity to collect, report, and use the measures to improve the quality of care for adults enrolled in Medicaid. In addition, the TEFT grant program is testing quality measurement tools for Medicaid LTSS for the first time on a national scale.

This report also demonstrates efforts CMS and states are undertaking to enhance oversight of the annual EQR process required of states contracting with managed care plans. These efforts include providing feedback to states on the EQRs and making information abstracted from the EQR technical reports on performance measures and improvement projects publicly available in this annual report.

CMS and states will continue to work together to measure performance and use data collected to drive improvements in the quality of health care. As the momentum to pay for value rather than volume of services grows, state-specific performance data will be critical in guiding efforts to transform the systems of care that provide services to Medicaid enrollees.

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EXHIBITS

1 Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010 22

2 Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013 23

3 Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013..... 24

4 Medicaid Health Plan Performance on Selected HEDIS 2013 Measures in the Medicaid Adult Core Set..... 25

5 Change in Medicaid Health Plan Performance on Selected HEDIS Measures in the Medicaid Adult Core Set, 2011–2013 27

6 Number and Percentage of Full-Benefit Adults, Ages 21–64, Enrolled in Medicaid by State and Service Delivery Type, CY 2010* 29

7 Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2013–2014 Reporting Cycle..... 31

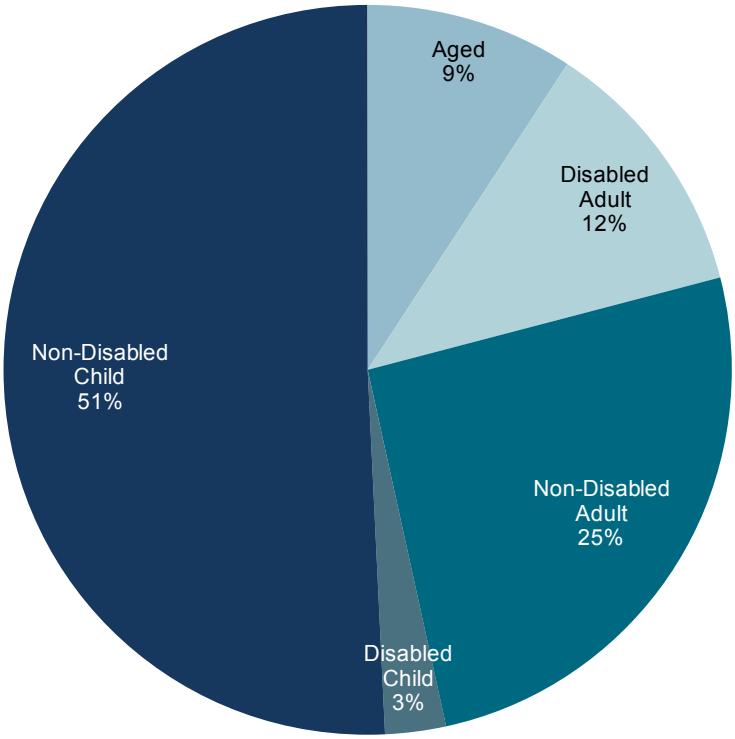
8 Diabetes Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle 34

9 Hospital Readmissions Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 36

10 Emergency Department (ED) Visits Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 38

11 Substance Use Disorders Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 40

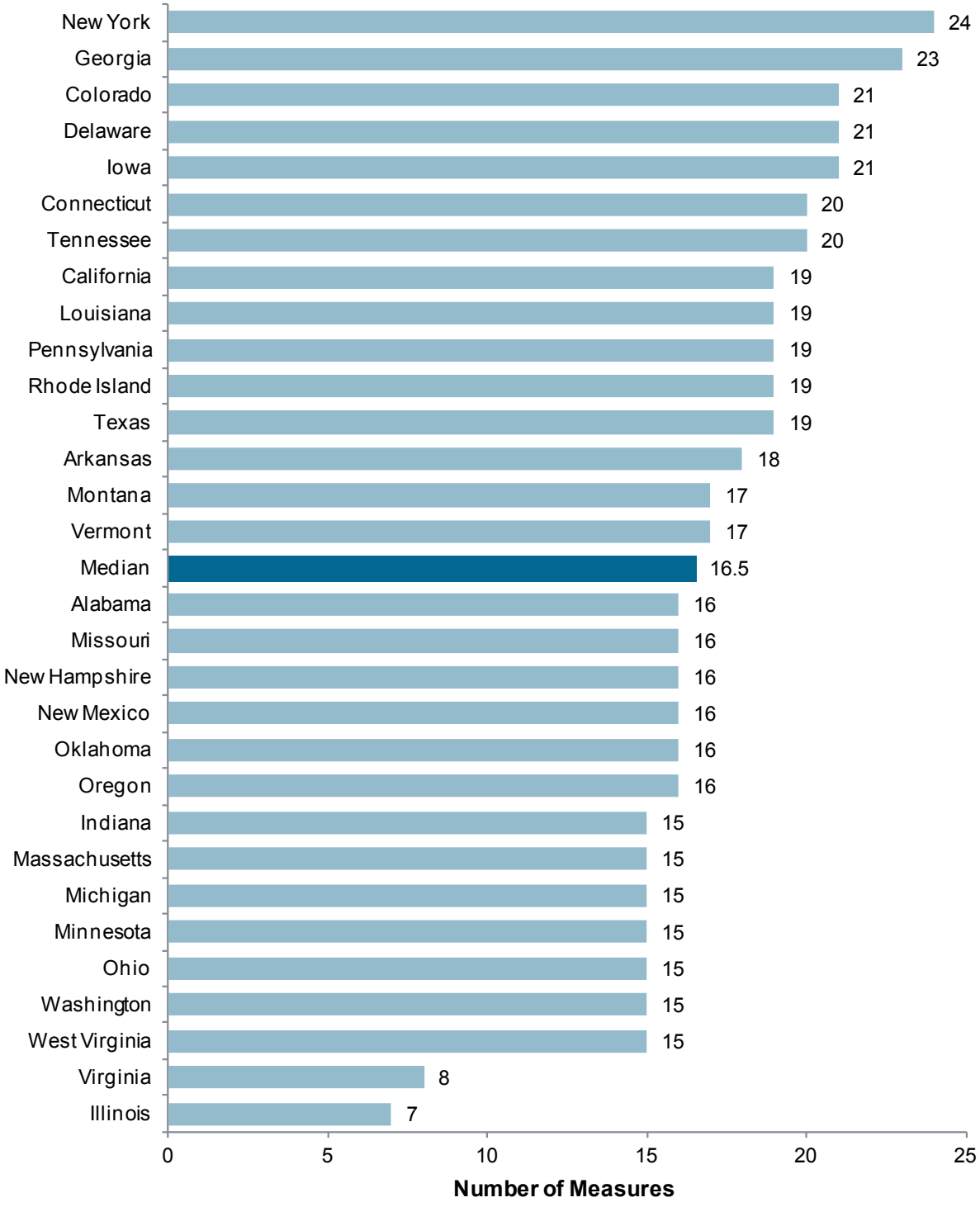
Exhibit 1. Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010



Source: Mathematica analysis of the 2010 Medicaid Analytic eXtract.

Notes: This analysis includes 69 million full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only). Adults are ages 18 to 64.

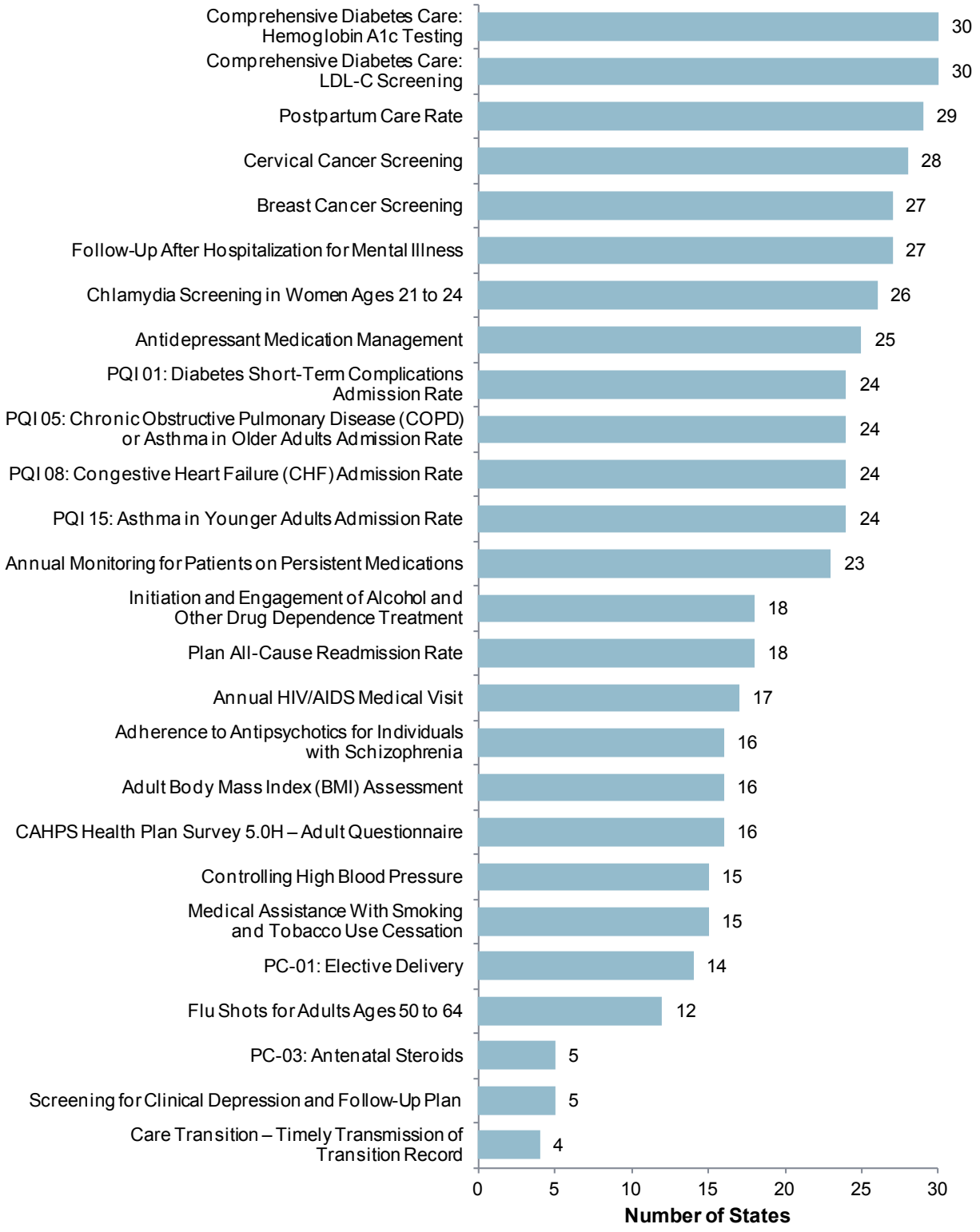
Exhibit 2. Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Adult CARTS reports.

Notes: This figure is based on state reporting of 26 Core Set measures for FFY 2013. The term "states" includes the 50 states and the District of Columbia.

Exhibit 3. Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Adult CARTS reports.

Note: The term "states" includes the 50 states and the District of Columbia.

Exhibit 4. Medicaid Health Plan Performance on Selected HEDIS 2013 Measures in the Medicaid Adult Core Set

Measure	Required for Accreditation	Number of Medicaid Health Plans Reporting (n = 213)	Percentage of Plans Reporting	Mean	Median	25th percentile	75th percentile
Adult Body Mass Index (BMI) Assessment	Yes	153	72	67.5	72.0	62.5	78.7
Breast Cancer Screening	Yes	165	77	51.9	51.5	46.5	57.8
Cervical Cancer Screening	Yes	192	90	64.5	66.4	59.0	71.9
Medical Assistance With Smoking and Tobacco Cessation							
Advising smokers and tobacco users to quit	Yes	130	61	75.6	76.2	72.6	79.6
Discussing cessation medications	No	130	61	45.9	45.2	40.3	51.4
Discussing cessation strategies	No	130	61	41.2	40.4	36.7	44.9
Chlamydia Screening in Women Ages 21 to 24	Yes	169	79	63.6	64.3	59.0	70.7
Follow-Up After Hospitalization for Mental Illness							
Within 30 days of discharge	No	100	47	63.6	65.8	56.8	75.6
Within 7 days of discharge	Yes	102	48	43.7	44.7	31.3	54.8
Controlling High Blood Pressure	Yes	179	84	56.3	56.2	50.0	63.0
Comprehensive Diabetes Care: LDL-C Screening	Yes	201	94	75.5	76.3	71.0	80.5
Comprehensive Diabetes Care: Hemoglobin A1c Testing	Yes	201	94	83.0	83.2	79.2	87.3
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	No	94	44	58.5	61.3	55.1	66.7
Antidepressant Medication Management							
Effective acute phase treatment	Yes	142	67	52.8	51.5	48.3	56.2
Effective continuation phase treatment	Yes	142	67	36.7	35.3	32.1	40.2
Annual Monitoring for Patients on Persistent Medications							
Ace inhibitors/ARB	No	176	83	86.3	87.1	84.6	89.2
Digoxin	No	94	44	90.2	90.8	87.5	93.2
Diuretic	No	174	82	86.0	86.7	83.8	89.1
Anticonvulsants	No	136	64	65.8	66.0	61.8	70.7
Total	No	176	83	84.5	85.4	82.4	87.3

Exhibit 4 (continued)

Measure	Required for Accreditation	Number of Medicaid Health Plans Reporting (n = 213)	Percentage of Plans Reporting	Mean	Median	25th percentile	75th percentile
CAHPS 5.0H							
Rating of all health care	Yes	135	63	50.9	51.0	47.8	53.8
Rating of personal doctor	Yes	135	63	63.1	63.1	60.0	66.7
Rating of specialist seen most often	Yes	121	57	64.4	64.0	61.3	67.2
Rating of health plan	Yes	135	63	56.3	56.6	51.6	60.7
Customer service	Yes	114	54	66.7	67.4	63.1	70.2
Getting care quickly	Yes	135	63	59.0	59.7	56.1	62.4
Getting needed care	Yes	135	63	55.1	55.7	52.4	58.5
How well doctors communicate	Yes	135	63	71.5	71.9	69.6	74.1
Shared decision making	No	119	56	50.5	50.5	48.3	52.1
Health promotion and education	No	135	63	27.7	27.8	25.1	30.1.
Coordination of care	No	119	56	54.4	54.8	51.5	58.1
Alcohol and Other Drug Dependence Treatment							
Initiation of AOD treatment	No	93	44	39.4	39.3	35.0	43.4
Engagement of AOD treatment	No	93	44	10.2	9.0	5.1	15.5
Postpartum Care Rate	Yes	191	90	63.0	64.0	57.9	70.2

Source: National Committee for Quality Assurance (NCQA) analysis of the national HEDIS 2013 database. These results reflect health plan performance in 2012.

Notes: Not all health plans submit the measures required for accreditation; reasons for not reporting a measure include insufficient denominators, non-reportable results, and not all health plans submitting data to the HEDIS database are accredited.

The 2013 national HEDIS database contains data for 213 Medicaid health plans (health maintenance organization [HMO] plans, point of service [POS] plans, and combination health plans) that voluntarily submitted HEDIS data to NCQA in June 2013. These health plans covered an estimated 27.3 million Medicaid beneficiaries in 37 states. This estimate includes Medicaid health plan enrollees of all ages, as these data are not separately available on the number of Medicaid health plan enrollees who are adults.

Exhibit 5. Change in Medicaid Health Plan Performance on Selected HEDIS Measures in the Medicaid Adult Core Set, 2011–2013

Measure	Number of Medicaid Health Plans Reporting 2011 (n =184)	Number of Medicaid Health Plans Reporting 2012 (n = 191)	Number of Medicaid Health Plans Reporting 2013 (n = 213)	HEDIS Median 2011	HEDIS Median 2012	HEDIS Median 2013	Percentage Point Change 2011–2013
Adult Body Mass Index (BMI) Assessment	117	130	153	47.6	57.9	72.0	24.4
Breast Cancer Screening	164	158	165	52.4	50.5	51.5	NS
Cervical Cancer Screening	172	173	192	69.7	69.1	66.4	-3.3
Medical Assistance With Smoking and Tobacco Cessation							
Advising smokers and tobacco users to quit*	118	116	130	74.8	75.1	76.2	n.a
Discussing cessation medications*	118	116	130	42.7	44.5	45.2	n.a
Discussing cessation strategies*	118	116	130	38.1	40.6	40.4	n.a
Chlamydia Screening in Women Ages 21 to 24	151	160	169	62.5	64.4	64.3	NS
Follow-Up After Hospitalization for Mental Illness							
Within 30 days of discharge	82	88	100	66.6	67.7	65.8	NS
Within 7 days of discharge	85	91	102	45.1	46.1	44.7	NS
Controlling High Blood Pressure	137	148	179	56.4	57.5	56.2	NS
Comprehensive Diabetes Care: LDL-C Screening	175	183	201	75.4	76.2	76.3	NS
Comprehensive Diabetes Care: Hemoglobin A1c Testing	175	183	201	82.2	82.4	83.2	NS
Adherence to Antipsychotic Medications for Individuals with Schizophrenia**	n.a.	n.a.	94	n.a.	n.a.	61.3	n.a.
Antidepressant Medication Management							
Effective acute phase treatment	90	97	142	50.1	49.4	51.5	1.4
Effective continuation phase treatment	90	97	142	32.7	32.4	35.3	2.6

Exhibit 5 (continued)

Measure	Number of Medicaid Health Plans Reporting 2011 (n =184)	Number of Medicaid Health Plans Reporting 2012 (n = 191)	Number of Medicaid Health Plans Reporting 2013 (n = 213)	HEDIS Median 2011	HEDIS Median 2012	HEDIS Median 2013	Percentage Point Change 2011–2013
Annual Monitoring for Patients on Persistent Medications							
Ace inhibitors/ARB	130	157	176	86.5	86.9	87.1	NS
Digoxin	59	75	94	90.3	91.0	90.8	NS
Diuretic	130	156	174	85.8	86.4	86.7	NS
Anticonvulsants	113	130	136	68.6	65.3	66.0	-2.6
Total	132	157	176	84.2	84.8	85.4	NS
CAHPS 5.0H							
Rating of all health care	129	128	135	49.2	50.0	51.0	NS
Rating of personal doctor	129	128	135	60.8	62.1	63.1	2.2
Rating of specialist seen most often	113	104	121	61.3	62.1	64.0	2.7
Rating of health plan	129	128	135	55.4	56.1	56.6	NS
Customer service	72	61	114	58.6	60.0	67.4	8.8
Getting care quickly	128	126	135	57.1	58.2	59.7	2.6
Getting needed care	125	120	135	50.2	49.8	55.7	5.5
How well doctors communicate	128	127	135	69.4	70.2	71.9	2.5
Shared decision making***	120	109	119	n.a.	n.a.	50.5	n.a.
Health promotion and education***	129	128	135	n.a.	n.a.	27.8	n.a.
Coordination of care	115	106	119	51.8	54.3	54.8	NS
Alcohol and Other Drug Dependence Treatment							
Initiation of AOD treatment	77	78	93	40.4	39.0	39.3	NS
Engagement of AOD treatment	77	78	93	13.3	11.4	9.0	-4.3
Postpartum Care Rate	165	180	191	64.6	65.0	64.0	NS

Source: National Committee for Quality Assurance (NCQA) analysis of the national HEDIS database.

Notes: The 2013 national HEDIS database contains data for 213 Medicaid health plans (health maintenance organization [HMO] plans, point of service [POS] plans, and combination health plans) that voluntarily submitted HEDIS data to NCQA in June 2013. These health plans covered an estimated 27.4 million adult Medicaid beneficiaries in 37 states. This estimate includes Medicaid health plan enrollees of all ages, as these data are not separately available on the number of Medicaid health plan enrollees who are adults.

NS = change in median performance from 2010 to 2012 was not statistically significant.

n.a. = not applicable; measure is either not reported by Medicaid health plans or there was a change in specification of the measure over time.

*Medical Assistance with smoking and tobacco cessation could not be compared between 2011 and 2013 due to a specification change in the measure.

**Adherence to Antipsychotic Medications for Individuals with Schizophrenia is a new measure for 2013.

***Indicator changed over time and could not be compared between 2011 and 2013.

Exhibit 6. Number and Percentage of Full-Benefit Adults, Ages 21–64, Enrolled in Medicaid by State and Service Delivery Type, CY 2010*

State	Total Number of Full-Benefit Adults	Managed Care		Fee-for-Service		Primary Care Case Management	
		Number	Percent	Number	Percent	Number	Percent
U.S. Total	12,922,368	7,880,635	61.0	1,660,247	12.8	3,381,486	26.2
Alabama	76,453	18	0.0	31,128	40.7	45,307	59.3
Alaska	26,031	0	0.0	0	0.0	26,031	100.0
Arizona	463,165	377,901	81.6	0	0.0	85,264	18.4
Arkansas	48,997	11	0.0	24,183	49.4	24,810	50.6
California	1,526,351	1,111,587	72.8	0	0.0	414,764	27.2
Colorado	132,941	9,326	7.0	2,923	2.2	120,692	90.8
Connecticut	246,061	144,543	58.7	0	0.0	101,518	41.3
Delaware	79,150	70,417	89.0	0	0.0	8,733	11.0
District of Columbia	80,067	69,491	86.8	0	0.0	10,576	13.2
Florida	702,045	237,127	33.8	100,561	14.3	364,357	51.9
Georgia	249,485	210,689	84.4	0	0.0	38,796	15.6
Hawaii	99,931	94,345	94.4	0	0.0	5,586	5.6
Idaho	30,743	0	0.0	18,384	59.8	12,359	40.2
Illinois	709,312	35,479	5.0	480,063	67.7	193,770	27.3
Indiana	240,268	211,245	87.9	126	0.1	28,897	12.0
Iowa	138,252	0	0.0	71,588	51.8	66,664	48.2
Kansas	47,031	31,967	68.0	714	1.5	14,350	30.5
Kentucky	129,968	27,796	21.4	85,485	65.8	16,687	12.8
Louisiana	145,657	0	0.0	76,757	52.7	68,900	47.3
Maine	114,941	0	0.0	64,871	56.4	50,070	43.6
Maryland	259,891	225,933	86.9	0	0.0	33,958	13.1
Massachusetts	315,207	157,572	50.0	126,161	40.0	31,474	10.0
Michigan	540,109	375,874	69.6	0	0.0	164,235	30.4
Minnesota	216,830	166,835	76.9	0	0.0	49,995	23.1
Mississippi	82,745	0	0.0	0	0.0	82,745	100.0

Exhibit 6 (continued)

State	Total Number of Full-Benefit Adults	Managed Care		Fee-for-Service		Primary Care Case Management	
		Number	Percent	Number	Percent	Number	Percent
Missouri	161,154	87,491	54.3	0	0.0	73,663	45.7
Montana	21,208	11	0.1	16,832	79.4	4,375	20.6
Nebraska	40,816	16,897	41.4	1,645	4.0	22,274	54.6
Nevada	61,386	44,213	72.0	0	0.0	17,173	28.0
New Hampshire	23,397	0	0.0	0	0.0	23,397	100.0
New Jersey	244,590	216,789	88.6	0	0.0	27,801	11.4
New Mexico	133,798	106,691	79.7	0	0.0	27,107	20.3
New York	2,157,903	1,771,401	82.1	6,436	0.3	380,066	17.6
North Carolina	304,368	0	0.0	200,697	65.9	103,671	34.1
North Dakota	16,727	0	0.0	11,511	68.8	5,216	31.2
Ohio	544,626	485,370	89.1	0	0.0	59,256	10.9
Oklahoma	105,340	0	0.0	50,121	47.6	55,219	52.4
Oregon	149,375	128,374	85.9	401	0.3	20,600	13.8
Pennsylvania	420,144	295,350	70.3	81,446	19.4	43,348	10.3
Rhode Island	59,260	46,150	77.9	0	0.0	13,110	22.1
South Carolina	145,026	85,264	58.8	14,621	10.1	45,141	31.1
South Dakota	20,748	0	0.0	13,655	65.8	7,093	34.2
Tennessee	308,319	307,876	99.9	0	0.0	443	0.1
Texas	369,526	161,479	43.7	94,056	25.5	113,991	30.8
Utah	84,418	12,094	14.3	15,621	18.5	56,703	67.2
Vermont	70,397	0	0.0	55,304	78.6	15,093	21.4
Virginia	144,695	102,207	70.6	11,323	7.8	31,165	21.5
Washington	192,482	136,049	70.7	2,173	1.1	54,260	28.2
West Virginia	58,098	36,459	62.8	1,461	2.5	20,178	34.7
Wisconsin	370,909	282,331	76.1	0	0.0	88,578	23.9
Wyoming	12,027	0	0.0	0	0.0	12,027	100.0

Source: Mathematica analysis of the 2010 Medicaid Analytic eXtract.

Notes: Managed care is defined in this context as enrollment in health maintenance organizations (HMOs) or health insuring organizations (HIOs) to provide a comprehensive set of services on a prepaid capitated risk basis. To protect privacy, state counts representing fewer than 11 people were recoded to 11 for the state count and for calculation of the state percentage.

*Adults include Medicaid enrollees ages 21 to 64 years as of December 31, 2010 who were not reported as eligible on the basis of disability. Individuals are reported in the service delivery system in which he or she was last covered for basic services in 2010.

Exhibit 7. Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2013–2014 Reporting Cycle

State	Number of PIPs for Adults	Years of Data	PIPs Validated[a]	Adult BMI	Asthma/ COPD	Behav. Health[b]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes	ED Visits	Hospital Readmissions	Preventive/ Chronic Care	Other[c]
Total PIPs	608	.	.	10	9	147	16	12	15	62	81	93	24	139
Total States	39			7	5	19	9	8	7	17	14	14	9	15
Arizona	22	PH & BH: 2010-2011; LTC: CY 2011	All	-	-	13*	-	-	-	-	-	9*	-	-
California	79	2011-2012	All	-	2	28	2	1	-	-	24*	25*	-	-
Colorado	8	Varies by PIP	All	1	-	6	-	-	-	-	-	-	1	-
Delaware	2	Not Reported	Some	-	-	-	-	-	-	-	2*	-	-	-
D.C.	4	2013	All	-	-	-	-	-	-	-	-	-	4	-
Florida	87	2012-2013	Some	1	-	32*	-	-	3	1	2	2	3	43
Georgia[d,e]	6	SFY 2013	All	-	-	-	-	-	-	3*	-	-	-	3*
Hawaii	14	Varies by PIP	All[f]	2	-	-	-	-	-	7*	-	5*	-	-
Illinois	5	SFY 2011	All[f]	-	-	-	-	-	3*	-	-	-	-	2
Indiana	9	Varies by PIP	Some	-	-	3	-	-	-	6	-	-	-	-
Iowa	2	Varies by PIP	Some	-	-	1	-	-	1	-	-	-	-	-
Kansas	2	Varies by entity	Some	-	-	-	-	-	-	2	-	-	-	-
Kentucky	6	CY 2012	All	-	-	2	1	-	-	-	3	-	-	-
Louisiana	6	Varies by PIP	All[f]	-	-	-	3	-	-	-	3*	-	-	-
Maryland	6	CY 2012	All	-	-	6*	-	-	-	-	-	-	-	-
Massachusetts	11	CY 2012	All[f]	-	-	1	-	-	-	2	-	7	-	1
Michigan	18	2012-2013	All	-	-	18*	-	-	-	-	-	-	-	-
Minnesota	12	Not Reported	All	-	3	-	4	-	-	4	-	-	1	-
Mississippi[g,h]	8	2012	All	2	-	-	-	2	-	2	2	-	-	-
Missouri	2	2009-2012	All[f]	-	-	-	-	-	-	1	-	1	-	-

Exhibit 7 (continued)

State	Number of PIPs for Adults	Years of Data	PIPs Validated[a]	Adult BMI	Asthma/ COPD	Behav. Health[b]	Cancer Screen-ing	Cardiac Care	Care Trans-itions	Diabetes	ED Visits	Hospital Readmis-sions	Preven-tive/ Chronic Care	Other[c]
Nebraska	3	Varied by PIP	All	-	-	-	1	-	-	-	2	-	-	-
Nevada	3	2012-2013	All	-	-	-	-	-	-	1	2*	-	-	-
New Jersey	1	CY 2012	All	1	-	-	-	-	-	-	-	-	-	-
New Mexico	6	2012-2013	All[f]	-	1	2	-	-	1	1	-	1	-	-
New York[i]	15	2011-2012	All	-	2	1	-	-	-	-	-	10	-	2
North Carolina	4	2012	All	-	-	1	-	-	-	-	-	-	-	3
Ohio	4	CY 2010	All[f]	-	-	-	-	-	-	-	-	-	-	4*
Oregon[j]	33	N/A	N/A	-	1	1	1	1	-	15*	1	4	4	5
Pennsylvania	23	CY 2012	Some	-	-	7*	-	-	-	-	5	8	1	2
Puerto Rico	12	CY 2012-2013	All[f]	1	-	-	-	2	-	4	-	5	-	-
Rhode Island[k,l]	8	2011-2012	All	-	-	1	1	-	-	-	-	-	2	4*
South Carolina	7	Not Reported	All	-	-	-	1	1	-	-	1	-	-	4
Tennessee	11	CY 2012	All	-	-	-	-	1	1	2	-	-	-	7
Texas	92	FY 2011	All	-	-	-	-	-	-	-	29	5	3	55
Vermont	1	2010-2011	All	-	-	-	-	1	-	-	-	-	-	-
Virginia[m]	7	CY 2011-2012	All	-	-	7	-	-	-	-	-	-	-	-
Washington	33	Varies by PIP	Some	2	-	9	2	-	5*	1	2	9	-	3
West Virginia	6	2012	All[f]	-	-	-	-	-	-	3*	3	-	-	-
Wisconsin	27	MCOs: CY 2011; LTC: FY 2012-2013	Some	-	-	8	-	3	1	7	-	2	5	1

Exhibit 7 (continued)

Source: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013-2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

* PIP topic was mandated by the state.

[a] EQR validation rating is the overall validation rating assigned to the PIP in the EQR technical report. EQROs used different rating systems in the validation process. EQRO discussion and recommendations are summarized from the EQR technical report's discussion of the validation results for each PIP, including strengths, limitations, and recommendations for improvement.

[b] "Behavioral health" is used as an umbrella term that includes mental health, substance use disorders, and other behavioral conditions such as ADHD. AHRQ, SAMHSA, and HRSA all employ the term "behavioral health" in this manner. For more information, see: AHRQ 2013 Lexicon for Behavioral Health and Primary Care Integration: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf. HRSA FAQs issued March 10, 2014: http://www.hrsa.gov/grants/apply/assistance/bhi/bhifaqs.pdf. SAMHSA mission statement: http://beta.samhsa.gov/about-us/who-we-are.

[c] "Other" includes PIPs on topics such as: customer/member satisfaction (FL, SC), balance billing (FL, TN), call center timeliness (FL, NC), and language and cultural services (FL, TN, WA).

[d] Georgia has a mandated PIP on provider satisfaction (3 MCOs).

[e] Georgia's PIP on provider satisfaction, which is captured in the "Other" category, was for members of all ages.

[f] This state's EQRO validated all of the PIPs mentioned in the technical report; it was unclear whether any additional PIPs were conducted, but not validated or mentioned in the technical report.

[g] Focused studies were submitted in place of PIPs. Carolinas Center for Medical Excellence (the EQRO) was directed by the state to review the projects as focused studies.

[h] Mississippi's Cardiac Care PIP, which focused on hypertension, was not validated by the EQRO.

[i] New York conducted two asthma PIPs that included both children and adult populations. One of those PIPs is represented in this table and the other is accounted for in Table 4 of the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

[j] Because this was the first full year of operation for Oregon's coordinated care organizations (CCOs), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

[k] Rhode Island has mandated PIPs in Chlamydia screening for women (2 MCOs) and use of imaging studies for low back pain (2 MCOs); these are captured in the "Other" category. Rhode Island also has a mandated PIP in initial health screens for special populations, which is captured in the "Preventive/Chronic Care" category.

[l] Two of Rhode Island's PIPs, focused on Chlamydia screening for women and initial health screens for special populations, included some children in the target population as well as adults.

[m] Virginia's behavioral health PIPs, which are focused on follow-up after hospitalization for mental illness, include all members ages 6 and older.

Behav. = behavioral; BH = behavioral health; BMI = body mass index; COPD = chronic obstructive pulmonary disease; CY = calendar year; EQRO = external quality review organization; ED = emergency department; FY = fiscal year; LTC = long-term care; PH = physical health; SFY = state fiscal year.

Exhibit 8. Diabetes Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Florida	1	None reported	No intervention information; met validation ratings	None reported
Georgia	3	HbA1c control, LDL-C control, Blood pressure control	Some intervention information; did not meet validation rating	Mixed results
Hawaii	7	Varied by MCO: HbA1c control, LDL-C control, Blood pressure control, retinal eye exams	Some intervention information; mixed validation rating information	Mixed results
Indiana	6	Varied by MCO: HbA1c control, LDL-C control, retinal eye exams	Some intervention information; validation ratings not reported	Mixed results
Kansas	2	Diabetic screening rates	No intervention information; validation will be completed in 2014	None reported
Massachusetts	2	Varied by MCO: HbA1c control, LDL-C control, nephropathy, retinal eye exams	Some intervention information; validation ratings not reported	Mixed results; None statistically significantly
Minnesota	4	Blood pressure control for individuals with diabetes	Some intervention information; validation ratings not reported	Mixed results
Mississippi	2	Quality and longevity of life of diabetes patients, use of screenings among diabetic patients	No intervention information; met validation ratings	None reported
Missouri	1	HbA1c control, LDL-C control, nephropathy, retinal eye exams	Some intervention information; met validation ratings	No improvement
Nevada	1	HbA1c testing, LDL-C screening, nephropathy screening	Some intervention information; met validation rating	No statistically significant improvement
New Mexico	1	HbA1c screening, LDL-C screening	Some intervention information; met validation rating	Statistically significant improvement on both measures
Oregon	15	HbA1c and LDL-C testing for members with diabetes and either schizophrenia or bipolar disorder	Some intervention information; PIPS were not validated as part of the 2013 EQR	First year of PIP; no outcomes reported
Puerto Rico	4	Blood pressure, glycosylated hemoglobin, LDL-C, ACE inhibitors, medication adherence, and smoking among diabetic members	Detailed intervention information; validation ratings not reported	None reported

Exhibit 8 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Tennessee	2	Diabetes monitoring in people with diabetes and schizophrenia	No intervention information; met validation ratings	None reported
Washington	1	Diabetes compliance	No intervention information; validation ratings not reported	None reported
West Virginia	3	Varies by entity; hemoglobin A1c control, retinal eye exam, HgBA1c testing, LDL-C level <100mg/dL	Some intervention information; validation ratings not reported	PIP in development stage; no outcomes reported
Wisconsin	7	None reported	No intervention information; validation ratings not reported	None reported

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCO), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Exhibit 9. Hospital Readmissions Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Arizona	9	Inpatient readmissions	No intervention information; validation ratings not reported	None reported
California	25	All-cause readmissions	Majority of the PIPs are in the design and implementation stage; one MCO reported focus group studies and team interventions; three MCOs "met" most of their reported sub-measures	Two MCOs reported results; one MCO found its consumers to have a lower 30-day readmission rate; one MCO reported baseline percentages for its first month of implementation
Florida	2	Varied by MCO: follow-up after discharge, behavioral health discharge planning, hospital readmission rates, inpatient psychiatric readmissions	No intervention information; two MCOs met validation ratings, 18 MCOs partially met validation ratings, three did not meet validation ratings	Collaborative PIP achieved statistically significant improvement; no results reported for other PIPs
Hawaii	5	Acute readmissions within 30 days	Some intervention information; met all validation ratings	No results reported; baseline rates reported for some MCOs
Massachusetts	7	Varied by MCO: readmission rates as a result of aftercare effectiveness, substance abuse services	Some intervention information; validation results varied; most met or partially met validation ratings or goals	Mixed results; one MCO showed statistically significant improvement
Missouri	1	Readmission rate	Some intervention information; met validation rating	Achieved reduction in readmission rate from baseline
New Mexico	1	Readmission rate	No intervention information; partially met validation rating	Achieved reduction in readmissions over a four-year period
New York	10	Varied by MCO; reduce readmission rates for all-cause and for behavioral health, obstetrical, and complex readmissions	Detailed intervention information; mixed validation results	Mixed results
Oregon	4	None reported	No intervention information; PIPs not validated in 2013 EQR	None reported

Exhibit 9 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Pennsylvania	8	Readmission rate	Detailed intervention information; varied validation ratings	Mixed results; some MCOs have yet to report their results
Puerto Rico	5	Varied by MCO: hospital readmissions, medication adherence	Some intervention information; varied validation results	Mixed results; data pending for four MCOs; improvement for one MCO
Texas	5	None reported	No intervention information; validation ratings not reported	None reported
Washington	9	Readmission rate	Some intervention information; one MCO met validation ratings, three partially met validation ratings, five did report validation ratings	None reported
Wisconsin	2	Readmission rate	Some intervention information; validation ratings not reported	One MCO achieved reduction in readmission rate

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

In addition to the PIPs represented here, AZ and IA conducted PIPs targeting hospital readmissions among children. Information on these PIPs is reflected in the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

This table does not include PIPs focused on follow-up care after a hospitalization.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCOs), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Exhibit 10. Emergency Department (ED) Visits Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
California	24	Avoidable ED visits among individuals 12+ years for non-emergent needs	Some intervention information; validation ratings not reported	Mixed results; statistically significant improvement for 14 MCOs; no improvement for 10 MCOs
Delaware	2	Rate of ED usage; no specific measures identified	No intervention information; low confidence validation ratings	Limited measurable improvement
Florida	2	Varied by MCO; ED use for non-emergency care, avoidable ED utilization	No intervention information; validation ratings not reported	None reported
Kentucky	3	Non-emergent/inappropriate ED utilization, ED care rates	Detailed intervention information; validation ratings not reported	Mixed results; no improvement for one MCO; no results reported for two MCOs
Louisiana	3	Percentage of ED visits per 1,000 member months that did not result in an inpatient stay	Detailed intervention information; validation ratings not reported	Baseline rate higher than the national average; no results reported
Mississippi	2	Rate of ED usage; no specific measures identified	No intervention information; partially met validation rating	No study question included in PIP documentation; no results reported
Nebraska	2	Varied by MCO; 30-day follow-up for non-emergent ED visits, ED overutilization	Detailed intervention information; validation ratings not reported	PIPs are in first year and results have not been reported
Nevada	2	Rate of ED usage; no specific measures identified	No intervention information; both received met validation ratings	None reported
Oregon	1	Rate of ED usage; no specific measures identified	Some intervention information; PIPs not validated for 2013 EQR	None reported
Pennsylvania	5	Rate of ED usage; no specific measures identified	Detailed intervention information; all MCOs met or partially met validation ratings	Mixed results; improvement for one MCO, no results reported for four MCOs
South Carolina	1	ED over-utilization; no specific measures identified	No intervention information; partially met validation rating	None reported

Exhibit 10 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Texas	29	ED visits; no specific measures identified	No intervention information; validation ratings not reported	None reported
Washington	2	Varied by MCO; avoidable ED visits, improving the medical homes for emergencies	Detailed intervention information; all MCOs met or partially met validation rating	Mixed results for one MCO; no results reported for one MCO
West Virginia	3	Varied by MCO; rate of ED visits for members ages 20-44, rate of ED visits for patients with a back pain diagnosis	Detailed intervention information; validation ratings not reported	Mixed results; improvement for two MCOs, mixed results for one MCO

Source: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013-2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs targeting adults from the submitted EQR technical reports.

In addition to the PIPs represented in this table, GA and MN also conducted PIPs targeting ER visits among children.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCO), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Exhibit 11. Substance Use Disorders Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Arizona	12	Members admitted to an acute inpatient setting with a diagnosis of chronic pain, substance abuse, anxiety and/or depression; members with an ED visit with a diagnosis of chronic pain, substance abuse, anxiety and/or depression; member deaths classified as accidental, suicide, or unknown	Some intervention information; validation ratings not yet reported as PIPs are still in implementation	PIPs are still in the implementation phase; baseline data was reported for calendar year 2012
California	3	Promote wellness and recovery for increased independence and improved functioning; reduce the number of crisis visits and inpatient hospitalization and spending for unplanned services; "A New Start for Moms" program integrating mental health and substance use disorder services	Detailed intervention information; two MCOs "met" most of sub-measures and one MCO "partially met" most of sub-measures	Two of the PIPs are still in the implementation or early planning phases and have no data to report; one PIP reported "intake" data for an unspecified number of consumers.
Kentucky	1	Smoke-free status of members who completed smoking cessation program at 7 days, 30 days, 60 days, 3 months, 6 months, 9 months, and 1 year; smoking cessation program completion rate	Detailed intervention information; met validation rating	No quantifiable improvement in smoke-free status; program completion rates increased slightly
Maryland	7	Initiation of alcohol and other drug dependence treatment; engagement of alcohol and other drug dependence treatment	Detailed intervention information; partially met validation ratings	Improvement for all MCOs on engagement measure; decline for all MCOs on initiation measure
Massachusetts	1	Aftercare rates for members who receive inpatient substance abuse services	Detailed intervention information; met goals	Statistically significant improvement for both of the MCO's indicators
New York	1	Use of NYS Quitline; CAHPS measures associated with smoking	Some intervention information; did not meet validation rating	No quantifiable improvement
Wisconsin	2	Varies by MCO; percentage of members who report an attempt to quit tobacco, rate of smoking cessation counseling	Some intervention information; one entity met validation rating, one partially met validation rating	Improvement for both MCOs; statistical significance not reported

Exhibit 11 (continued)

Source: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

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APPENDIX A

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

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Exhibit A.1. 2013 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

NQF #	Measure	Measure steward	Data source	Alignment with other programs
0039	Flu Shots for Adults Ages 50 to 64	NCQA	Survey	HEDIS, NCQA Accreditation
NA	Adult Body Mass Index (BMI) Assessment	NCQA	Administrative or hybrid	HEDIS, Health Home Core Set
NA	Breast Cancer Screening	NCQA	Administrative	MU1, HEDIS, NCQA Accreditation, PQRS GPRO, Shared Savings Program
0032	Cervical Cancer Screening	NCQA	Administrative or hybrid	MU1, HEDIS, NCQA Accreditation
0027	Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	Survey	MU1, HEDIS, Medicare, NCQA Accreditation
0418	Screening for Clinical Depression and Follow-Up Plan	CMS	Administrative and medical record	PQRS, CMS QIP, Health Home Core Set, Shared Savings Program
1768	Plan All-Cause Readmission Rate	NCQA	Administrative	HEDIS
0272	PQI 01: Diabetes Short-Term Complications Admission Rate	AHRQ	Administrative	None
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	AHRQ	Administrative	Shared Savings Program
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ	Administrative	Shared Savings Program
0283	PQI 15: Asthma in Younger Adults Admission Rate	AHRQ	Administrative	None
0033	Chlamydia Screening in Women Ages 21 to 24	NCQA	Administrative	MU1, HEDIS, NCQA Accreditation, Child Core Set
0576	Follow-Up After Hospitalization for Mental Illness	NCQA	Administrative	HEDIS, NCQA Accreditation, Child Core Set, Health Home Core Set
0469	PC-01: Elective Delivery	TJC	Administrative and medical record	HOP QDRP, TJC's ORYX Performance Measurement Program
0476	PC-03: Antenatal Steroids	TJC	Administrative and medical record	TJC's ORYX Performance Measurement Program
NA	Annual HIV/AIDS Medical Visit	NCQA	Administrative	None
0018	Controlling High Blood Pressure	NCQA	Hybrid	MU1, HEDIS, NCQA Accreditation, PQRS GPRO, Shared Savings Program
0063	Comprehensive Diabetes Care: LDL-C Screening	NCQA	Administrative or hybrid	MU1, HEDIS, NCQA Accreditation, PQRS
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA	Administrative or hybrid	MU1, HEDIS, NCQA Accreditation, PQRS
0105	Antidepressant Medication Management	NCQA	Administrative	MU1, HEDIS, NCQA Accreditation
NA	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA	Administrative	HEDIS, VHA
NA	Annual Monitoring for Patients on Persistent Medications	NCQA	Administrative	HEDIS, NCQA Accreditation
0007	CAHPS Health Plan Survey 5.0H – Adult Questionnaire	AHRQ NCQA	Survey	HEDIS, NCQA Accreditation, Shared Savings Program
0648	Care Transition – Transition Record Transmitted to Health Care Professional	AMA/PCPI	Administrative and medical record	Health Home Core Set
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	Administrative	MU1, HEDIS, Health Home Core Set
1517	Postpartum Care Rate	NCQA	Administrative or hybrid	HEDIS

AHRQ = Agency for Healthcare Research and Quality; AMA/PCPI = American Medical Association-convened/Physician Consortium for Performance Improvement; HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance; MU1= Meaningful Use Stage 1; PQRS = Physician Quality Reporting System; GPRO = Group Practicing Reporting Option; CMS QIP = Centers for Medicare & Medicaid Services Quality Improvement Program; HOP QDRP = Hospital Outpatient Quality Data Reporting Program; TJC ORYX = The Joint Commission ORYX; VHA = Veteran's Health Administration.

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APPENDIX B

NUMBER OF MEDICAID HEALTH PLANS REPORTING HEDIS OR CAHPS MEASURES FOR ADULTS TO NCQA

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Exhibit B.1. Number of Medicaid Health Plans Reporting HEDIS or CAHPS Measures for Adults to NCQA, by Region and State, HEDIS 2011–2013

Region and State	HEDIS 2011	HEDIS 2012	HEDIS 2013
Total number of plans reporting	184	191	213
Northeast (5 states)	20	18	22
Connecticut	3	0	2
Massachusetts	4	5	5
New Jersey	3	3	4
New York	8	8	9
Rhode Island	2	2	2
Mid-Atlantic (6 states)	27	29	29
Delaware	2	2	2
District of Columbia	3	3	2
Maryland	8	8	8
Pennsylvania	6	8	8
Virginia	5	5	6
West Virginia	3	3	3
South (9 states)	40	44	53
Florida	14	18	16
Georgia	3	3	3
Kentucky	1	1	4
Louisiana	0	0	2
Mississippi	0	0	2
New Mexico	6	6	6
South Carolina	4	4	4
Tennessee	7	7	7
Texas	5	5	9
Midwest (11 states)	61	63	64
Colorado	2	2	2
Illinois	2	2	4
Indiana	5	4	4
Kansas	1	2	1
Michigan	14	14	13
Minnesota	9	7	7
Missouri	7	6	2
Nebraska	1	2	3
Ohio	7	7	7
Utah	1	1	3
Wisconsin	12	16	18
West (6 states)	36	37	45
Arizona	1	1	1
California	24	23	30
Hawaii	1	3	6
Nevada	2	2	2
Oregon	1	1	1
Washington	7	7	5

Source: National Committee for Quality Assurance (NCQA) analysis of the national HEDIS database.

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APPENDIX C

GLOSSARY

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GLOSSARY

AHRQ	Agency for Healthcare Research and Quality
Affordable Care Act	The Patient Protection and Affordable Care Act
AMA/PCPI	American Medical Association-convened/Physician Consortium for Performance Improvement
AOD	Alcohol or Other Drug
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARE	Continuity Assessment Record and Evaluation
CB-LTSS	Community-based Long Term Services and Supports
CCO	Coordinated Care Organization
CHCS	Center for Health Care Strategies
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization
EDI	Employer Sponsored Insurance
FFY	Federal Fiscal Year
GPRO	Group Practice Reporting Option
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
HOP QDRP	Hospital Outpatient Quality Data Reporting Program
LEP	Limited English Proficiency
LTSS	Long-term Services and Supports
MACBIS	Medicaid and CHIP Business Information Solutions
MAP	Measure Applications Partnership

MCO	Managed Care Organization
MEPS	Medical Expenditure Panel Survey
MU1	Meaningful Use Stage 1
National Quality Strategy	National Quality Strategy for Quality Improvement in Health Care
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
POS	Point of Service Plans
PPO	Preferred Provider Organization
PQRS	Physician Quality Reporting System
QIP	Quality Improvement Project
TA/AS	Technical Assistance and Analytic Support
TEFT	Testing Experience and Functional Assessment Tools
TJC	The Joint Commission
VHA	Veteran's Health Administration